DOCUMENT RESUME

ED 323 475 CG 022 798

TITLE Beyond the Stereotypes: Women, Addiction, and Perinatal Substance Abuse. Hearing before the Select Committee on Children, Youth and Families. House of Representatives, One Hundred First Congress, Second Session.

INSTITUTION Congress of the U.S., Washington, DC. House Select Committee on Children, Youth, and Families.

PUB DATE 19 Apr 90

NOTE 201p.; Portions contain small print.

AVAILABLE FROM Superintendent of Documents, U.S. Government Printing Office, Congressional Sales Office, Washington, DC 20402.

PUB TYPE Legal/Legislative/Regulatory Materials (090)

EDRS PRICE MF01/PC09 Plus Postage.

DESCRIPTORS Alcohol Abuse; *Child Abuse; Child Advocacy; Child Custody; Child Health; Child Neglect; Child Welfare; Disadvantaged Environment; Drug Abuse; Family Environment; Family Violence; Federal Government; Federal Programs; *Females; Hearings; One Parent Family; *Perinatal Influences; Poverty; *Pregnancy; *Substance Abuse

IDENTIFIERS Congress 101st

ABSTRACT

The hearing reported in this document was called to address the human havoc wreaked by substance abuse among pregnant women in America. Witnesses included leading scientists and innovative service providers qualified to supply the best information on chemically dependent women across the country and to point the way to a better understanding of the range of their needs. Statements were made by the following participants: (1) Douglas J. Besharov, resident scholar, American Enterprise Institute, Washington, D.C.; (2) Sheila Blume, M.D., C.A.C., medical director, alcoholism, chemical dependency and compulsive gambling programs, South Oaks Hospital, Amityville, NY; (3) Iris E. Smith, director, prevention and applied research, Laboratory of Human and Behavior Genetics, Emory University School of Medicine, Atlanta, GA; (4) Alan I. Trachtenberg, M.D., M.P.H., medical director, Bay Area Addiction Research and Treatment, Berkeley, CA; (5) Reed V. Tuckson, M.D., Senior Vice President for Programs, March of Dimes Birth Defects Foundation, White Plains, NY; (6) Kathleen 'X', parent, Germantown, MD; and (7) Jing Ja Yoon, M.D., Clinic of Neonatology, Bronx Lebanon Hospital Center, Bronx, NY. A large number of prepared statements, letters, and supplemental materials were also read into the proceedings and are included in the report. (TE)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

CG

BEYOND THE STEREOTYPES: WOMEN, ADDICTION, AND PERINATAL SUBSTANCE ABUSE

ED323475

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, APRIL 19, 1990

Printed for the use of the
Select Committee on Children, Youth, and Families

CG022798

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

This document has been reproduced as received from the person or organization originating it.

Minor changes have been made to improve reproduction quality.

Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

U.S. GOVERNMENT PRINTING OFFICE

31-228 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

GEORGE MILLER, California, *Chairman*

WILLIAM LEHMAN, Florida
PATRICIA SCHROEDER, Colorado
LINDY (MRS. HALE) BOGGS, Louisiana
MATTHEW F. McHUGH, New York
TED WEISS, New York
BERYL ANTHONY, Jr., Arkansas
BARBARA BOXER, California
SANDER M. LEVIN, Michigan
BRUCE A. MORRISON, Connecticut
J. ROY ROWLAND, Georgia
GERRY SIKORSKI, Minnesota
ALAN WHEAT, Missouri
MATTHEW G. MARTINEZ, California
LANE EVANS, Illinois
RICHARD J. DURBIN, Illinois
DAVID E. SKAGGS, Colorado
BILL SARPALIUS, Texas

THOMAS J. BLILEY, Jr., Virginia
FRANK R. WOLF, Virginia
BARBARA F. VUCANOVICH, Nevada
RON PACKARD, California
J. DENNIS HASTERT, Illinois
CLYDE C. HOLLOWAY, Louisiana
CURT WELDON, Pennsylvania
LAMAR S. SMITH, Texas
PETER SMITH, Vermont
JAMES T. WALSH, New York
RONALD K. MACHTLEY, Rhode Island
TOMMY F. ROBINSON, Arkansas

COMMITTEE STAFF

KARABELLE PIZZIGATI, *Staff Director*
JILL KAGAN, *Deputy Staff Director*
DENNIS G. SMITH, *Minority Staff Director*
CAROL M. STATUTO, *Minority Deputy Staff Director*

CONTENTS

	Page
Hearing held in Washington, DC, April 19, 1990	1
Statement of:	
Besharov, Douglas J., resident scholar, American Enterprise Institute, Washington, DC	46
Blume, Sheila B., M.D., C.A.C., medical director, alcoholism, chemical dependency and compulsive gambling programs, South Oaks Hospital, Amityville, NY	57
Smith, Iris E., director, prevention and applied research, Laboratory of Human and Behavior Genetics, Emory University School of Medicine; project director, Georgia Addiction, Pregnancy and Parenting Program (GAPP), Atlanta, GA	85
Trachtenberg, Alan I. M.D., M.P.H. medical director, Bay Area Addiction Research and Treatment (BAART), Berkeley, CA	102
Tuckson, Reed V., M.D., senior vice president for programs, March of Dimes Birth Defects Foundation, White Plains, NY	32
'X' Kathleen, Parent, Germantown, MD	24
Yoon, Jing Ja, M.D., Chief of Neonatology, Bronx Lebanon Hospital Center, Bronx, NY	114
Prepared statements, letters, supplemental materials, et cetera:	
Besharov, Douglas J., resident scholar, American Enterprise Institute, Washington, DC, prepared statement of	49
Bliley, Hon. Thomas J. Jr., a Representative in Congress from the State of Virginia and ranking Republican Member:	
Beyond the Stereotypes: Women, Addiction, and Perinatal Abuse (Minority fact sheet)	12
Opening statement of	10
Blume, Sheila B., M.D., C.A.C., medical director, Alcoholism, Chemical Dependency and Compulsive Gambling Programs, South Oaks Hospital, Amityville, New York:	
Letter to Chairman George Miller, dated May 15, 1990, with response to questions	164
American Medical Women's Association, Inc., Position Paper on Tobacco	67
American Society of Addiction Medicine, ASAM NEWS, vol. IV, No. 5, September–October 1989, article entitled	65
Prepared statement of	60
Kleber, Dr. Herbert D., deputy director for Demand Reduction, Office of National Drug Control Policy, Executive Office of the President, Washington, DC, prepared statement of	156
Lex, Barbara W., Ph.D., M.P.H., Member, American Anthropological Association Task Force on Alcohol and Drugs, Assistant Professor of Psychiatry (Anthropology), Harvard Medical School, Boston, MA, prepared statement of	130
Lipscombe, Dr. Trevor, research coordinator, Covenant House (Advocacy), New York, NY, prepared statement of	143
Miller, Hon. George, a Representative in Congress from the State of California, and Chairman, Select Committee on Children, Youth, and Families:	
Letter to Alan Trachtenberg, M.D., M.P.H., dated May 7, 1990, requesting answer to question posed by Chairman George Miller	172
Letter to Iris Smith, M.P.H., dated May 7, 1990, requesting answers to questions posed by Chairman George Miller	192
Letter to Kathleen J. Tavenner, C.A.C., dated May 7, 1990, requesting answers to questions posed by Chairman George Miller	176

Page

Prepared statements, letters, supplemental materials, et cetera—Continued
Miller, Hon. George, a Representative in Congress from the State of California, and Chairman, Select Committee on Children, Youth, and Families—Continued
Letter to Reed V. Tuckson, M.D., dated May 7, 1990, requesting answers to questions posed by Chairman George Miller 181
Letter to Sheila B. Blume, M.D., dated May 7, 1990, requesting answers to questions posed by Chairman George Miller 162
Opening statement of 3
Women, Addiction, and Perinatal Substance Abuse (a fact sheet) 4
Shahrivar, Farrokh, M.D., associate director of Pediatrics/chief, Neonatology Division, St. Luke's-Roosevelt Hospital Center, New York, NY, prepared statement of 152
Smith, Iris E., M.P.H., director, Prevention and Applied Research, Laboratory of Human and Behavior Genetics, Emory University School of Medicine, Project Director, Georgia Addiction, Pregnancy and Parenting Program (GAPP), Atlanta, GA:
Letter to Chairman George Miller, dated May 31, 1990, with response to questions 195
Prepared statement of 89
Tavenner, Kathleen, MTC, Inc., Emmitsburg, MD, letter to Chairman George Miller dated, May 15, 1990, with response to questions 177
Trachtenberg, Alan I., M.D., M.P.H., Medical Director, Bay Area Addiction Research and Treatment (BAART) and the Family Addiction Center for Education and Treatment (FACET), Berkeley, CA:
Letter to Chairman George Miller, dated May 24, 1990, with response to question 173
Prepared statement of 105
Tuckson, Reed V., M.D., senior vice president for programs, March of Dimes Birth Defects Foundation, White Plains, NY:
Prepared statement of 35
Response to questions posed by Chairman George Miller 183
'X', Erin, Germantown, MD, prepared statement of 31
'X', Kathleen, Parent, Germantown, MD, prepared statement of 28
Yoon, Jing Ja, M.D., chief of Neonatology, Bronx-Lebanon Hospital Center, Bronx, NY, prepared statement of 117

BEYOND THE STEREOTYPES: WOMEN, ADDICTION, AND PERINATAL SUBSTANCE ABUSE

THURSDAY, APRIL 19, 1990

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m., in Room 2325, Rayburn House Office Building, the Hon. George Miller [chairman] presiding.

Members present: Representatives Miller, Boggs, Levin, Martinez, Evans, Bliley, Hastert, and Machtley.

Staff present: Karabelle Pizzigati, staff director; Jill Kagan, deputy staff director; May Kennedy, professional staff; Joan Silverstein, research assistant; Dennis Smith, minority staff director; Carol Statuto, minority deputy staff director, and Joan Godley, committee clerk.

Chairman MILLER. The Select Committee on Children, Youth, and Families will come to order for the purposes of conducting a hearing titled "Beyond the Stereotypes: Women, Addiction, and Perinatal Substance Abuse."

During the last few years we've become increasingly aware of the human havoc wreaked by substance abuse. In 1989, as many as 1 in 10 pregnant women used crack cocaine with devastating consequences. Millions more used other illicit and legal drugs that posed serious and potentially life-threatening problems to themselves and to their babies.

In 1986, this select committee held its first inquiry into the effects of parental substance abuse on infants. Witnesses warned us then and in subsequent hearings of the burgeoning problem and the need to provide adequate services to women before, during and after pregnancy both to insure healthier birth outcomes and to reduce the incidence of perinatal substance abuse.

They also confirmed what we already know about addressing similar problems: it is more humane and cost effective to provide adequate early care or treatment than to solve neglected and entrenched problems. Despite repeated warnings we have neither listened well nor acted with sufficient speed and reason.

A select committee survey of hospitals in large metropolitan areas last year revealed that two-thirds had no place to refer substance abusing pregnant women for treatment. Of a handful of drug treatment programs that accept pregnant women, most ignore critical service needs such as child care.

With nowhere to turn for treatment, women in more than a dozen states are also facing jail sentences for fetal drug exposure. We know the tragic impact of perinatal substance abuse on children, but we must address more attention to the broader context, to the addicted women themselves, in order to enable them both to recover from the addiction and to gain self-sufficiency to care for themselves and their children.

Frequently victims themselves of physical and sexual abuse, poverty and a lack of access to medical treatment, drug abusing women of childbearing age represent a critical link in the chain of lost human possibilities.

The problem of perinatal substance abuse is an urgent and a complicated problem. For that reason, the select committee will hold a series of hearings on this topic over the next several weeks.

Nor are drugs the only crisis these high-risk women confront. The effects of drug exposure may be compounded by exposure to HIV infection. The Centers for Disease Control reports that nearly fourth-fifths, some 78 percent of children who test positive for HIV at birth, have mothers who are intravenous drug users, or have mothers whose partners have used drugs.

Criminal drug abuse is not the only culprit. Legal drug use during pregnancy can represent as serious a health problem as illicit drug use. Tobacco and alcohol companies continue to target women of childbearing age through advertising campaigns and inappropriate prescription drug use remains high.

A new study involving more than 600 chemically dependent pregnant women in Michigan has documented a range or problems due to legal and illicit substance abuse among pregnant women. This study finds that as the severity of drug use increased, the amount and quality of prenatal care declined and birth outcomes worsened. We will learn more about this study in our next hearing in Detroit on Monday, that will focus on the treatment issues.

Today we hope to learn what is known about chemically dependent women and their need for guidance, support and comprehensive treatment. The members of this committee are all extremely concerned about the fates of the most visible victims of perinatal substance abuse, the infants; but we must either take the need for drug abuse prevention and treatment for women very seriously indeed, or accept an ever increasing number of babies born hooked.

Among our witnesses today are leading scientists and innovative service providers who will provide the best information describing the circumstances and diversity of women across the country who are chemically dependent in order to help us understand better the range of their needs. We are especially pleased to welcome a woman who has overcome her problem with addiction and has gone on to help other women in the same situation.

One of our stereotypes is that this problem is confined to northeastern urban centers so we are particularly interested in hearing from our witness from Atlanta. We are eager to learn about what is known currently, as well as the important questions that remain unanswered. I want to thank in advance all of the witnesses for coming.

[Opening statement of Hon. George Miller follows:]

OPENING STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

During the last few years, we have all become increasingly aware of the human havoc wreaked by substance abuse. In 1989, as many as 1 in 10 pregnant women used crack-cocaine with devastating consequences. Millions more used other illicit and legal drugs that pose serious and potentially life-threatening problems to themselves and their babies.

In 1986, this Select Committee held its first inquiry into the effects of parental substance abuse on infants. Witnesses warned us then, and in subsequent hearings, of the burgeoning problem and the need to provide adequate services to women before, during and after pregnancy to both ensure healthier birth outcomes and to reduce the incidence of perinatal substance abuse. They also confirmed what we already know about addressing many similar problems: it is more humane and cost-effective to provide adequate early care and treatment than to solve neglected and entrenched problems.

Despite repeated warnings, we have neither listened well nor acted with sufficient speed and reason.

A Select Committee survey of hospitals in large metropolitan areas last year revealed that two-thirds had no place to refer substance abusing pregnant women for treatment.

Of the handful of drug treatment programs that accept pregnant women, most ignore critical service needs such as child care.

And, with nowhere to turn for treatment, women in more than a dozen states are also facing jail sentences for fetal drug exposure.

We know the tragic impact of perinatal substance abuse on children. But we also must direct more attention to the broader context—to addicted women themselves in order to enable them both to recover from addiction and to gain self-sufficiency to care for themselves and their children.

Frequently victims themselves of physical or sexual abuse, poverty, and lack of access to medical treatment, drug-abusing women of childbearing age present a critical link in a chain of lost human possibilities.

The problem of perinatal substance abuse is an urgent and complicated problem. For that reason, the Select Committee will hold a series of hearings on this topic over the next several weeks.

Nor are drugs the only crisis these high-risk women confront. The effects of drug exposure may be compounded by exposure to HIV infection. The Centers for Disease Control reports that nearly four-fifths—some 78%—of children who test positive for HIV at birth have mothers who are intravenous drug users, or mothers whose partners abused drugs.

But criminal drug use is not the only culprit. Legal drug use during pregnancy can present as serious a health hazard as illicit drug use. Tobacco and alcohol companies continue to target women of childbearing age through advertising campaigns and inappropriate prescription drug use remains high.

A new study involving more than 600 chemically dependent pregnant women in Michigan has documented a range of problems due to legal and illicit substance abuse among pregnant women. This study finds that as the severity of drug use increased, the amount and quality of prenatal care declined, and birth outcomes worsened. We will learn more about this study at our next hearing in Detroit on Monday that will focus on treatment issues.

Today we hope to learn what is known about chemically dependent women and their need for guidance, support, and comprehensive treatment.

The members of this Committee are all extremely concerned about the fates of the most visible victims of perinatal substance abuse—the infants. But we must either take the need for drug abuse prevention and treatment for women very seriously indeed, or accept and ever-increasing number of babies "born hooked."

Among our witnesses today are leading scientists and innovative service providers who will provide the best information describing the circumstances and diversity of women across the country who are chemically dependent, in order to understand better the range of their needs.

We are especially pleased to welcome a woman who has overcome her problems with addiction, and has gone on to help other women in the same situation. One of our stereotypes is that this problem is confined to Northeastern urban centers, so we are particularly interested in hearing from our witness from Atlanta. We are eager to learn about what is known currently, as well as about important questions that remain unanswered.

Thank you all for coming.

WOMEN, ADDICTION, AND PERINATAL SUBSTANCE ABUSE

FACT SHEET

ILLICIT DRUG USE UP AMONG MILLIONS OF WOMEN ACROSS SOCIOECONOMIC GROUPS

- Over 5 million women of childbearing age (15-44) currently use an illicit drug, including almost 1 million who use cocaine and 3.8 million who use marijuana. (National Institute of Drug Abuse [NIDA], 1989)

- In a recent survey of 715 pregnant women in Pinellas County, Florida, nearly 15% tested positive for substance use, with no significant difference among socioeconomic groups. (National Association for Perinatal Addiction Research and Education [NAPARE], 1989)

- While actual drug use may not be significantly higher among pregnant minority women, they are ten times more likely than white women who use drugs to be reported to child abuse authorities. (NAPARE, 1989)

HEAVY SMOKING, ALCOHOL USE ON THE RISE AMONG YOUNG WOMEN

- Approximately 6 million American women are alcoholic or alcohol abusers. Despite stable drinking patterns among the general population over the past 25 years, recent studies indicate an increase among younger women who are heavy drinkers (5 drinks a day or more). (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1987; NIAAA, unpublished, 1990)

- Nearly 24% of American women smoke and the fastest growing group of smokers in this country are women under age 23. Every day, 2,000 young women start smoking. The percentage of women who smoke 25 or more cigarettes a day increased from 13% in 1965 to 23% in 1985. (Surgeon

General's Report [SGR], 1989; U.S. Department of Health and Human Services [DHHS], February 1990)

- Although pregnant women are just as likely as nonpregnant women to have ever smoked (43% to 45% respectively), pregnant women (21%) are less likely than nonpregnant women (30%) to be current smokers. Black women were the least likely of any group to smoke during pregnancy. (Williamson, 1989)

PREGNANT SUBSTANCE ABUSERS AT GREAT RISK OF AIDS, SEXUALLY TRANSMITTED DISEASES AND HOMELESSNESS

- In a survey of 337 pregnant substance abusers in 63 AIDS demonstration projects nationwide, 20% are homeless and 23% spent time in jail six months prior to the interview. (NIDA, unpublished data, 1990)

- Of the same 337 women, 36% engaged in sex for drugs or money, placing themselves and their babies at high risk for HIV infection; 98% engaged in vaginal sex, while only 4% used condoms consistently; and 15% had a sexually transmitted disease in the past 6 months. (NIDA, 1990)

- In New York City, pregnant cocaine abusers were 4.5 times more likely than nonusers to have a sexually transmitted disease. (New York City Department of Health [NYCDH], September 1989)

TREATMENT/PRENATAL CARE ELUSIVE FOR SUBSTANCE-ABUSING PREGNANT WOMEN AND MOTHERS

- At Boston City Hospital, 80% of mothers surveyed who used heroin or cocaine received no prenatal care. New York City cocaine abusers were 7 times less likely than non-abusers to have received prenatal care. (Amaro, 1989; NYCDH, 1989)

- Of 78 drug treatment programs surveyed in New York City, 54% exclude all pregnant women; 67% will not accept

pregnant women on Medicaid; and 87% will not accept pregnant crack-addicted women on Medicaid. (Chavkin, 1989)

- Of California's 366 publicly-funded drug treatment programs, only 67 treat women and only 16 can accommodate her children. Similarly, Ohio has 16 women's recovery programs, and only two can accommodate her children. (Weissman, 1990; Ohio Department of Health, 1990)

- Reports show that 23% of women entering treatment, as compared to only 2% of men, encounter opposition from families and friends. Similarly, 48% of women experienced problems due to entering treatment, as compared to 20% of men. (Beckman and Amaro, 1984)

EFFECTIVE TREATMENT APPROACHES DOCUMENTED

- Pregnant women who participated in a smoking cessation program at a Michigan WIC clinic were 3.6 times more likely to quit smoking than nonparticipants. (Mayer, 1990)

- In a study of alcohol-using pregnant women in Atlanta, 35% discontinued alcohol use when presented information on the potential harm of alcohol use during pregnancy. (Smith, 1986)

- In Pinellas County, Florida, 77% of male and female substance abusers who are referred by the courts to Operation PAR, a comprehensive drug treatment program, and who complete the 18-to 24-month program do not re-enter the criminal justice system. (Florida Department of Corrections, 1989)

- Of 54 babies born in 1989 to cocaine-using mothers enrolled at the Philadelphia Family Center, an outpatient drug treatment program for pregnant women and children, 75% were carried to full term. None were born prior to 33 weeks gestation. (Philadelphia Family Center, 1990)

INFANTS SERIOUSLY AFFECTED BY PERINATAL SUBSTANCE ABUSE

- A new eight-city survey reported that nearly 9,000 babies were born exposed to illicit drugs in 1989 at an estimated cost of $500 million for providing care through age 5. (Office of the Inspector General, 1990)

- Each year, Fetal Alcohol Syndrome (FAS) affects nearly 5,000 babies and is the third leading cause of birth defects associated with mental retardation. Thousands more children are born with Fetal Alcohol Effects (FAE), a milder form of FAS. (National Council on Alcoholism and Drug Dependency, 1988)

- Smoking increases premature deliveries, spontaneous abortions and still births. A pregnant smoker's infant is on average seven ounces lighter than babies of nonsmokers. (SGR, 1989)

- Between 1985 and 1988, the number of congenital syphilis cases increased by 130%. Experts estimate that there will be over 1,000 congenital syphilis cases in 1989. (Centers for Disease Control [CDC], 1990)

- As of February, 1990, there have been 2,116 reported cases of pediatric AIDS in children under age 13. Eighty percent of these pediatric AIDS cases are attributed to maternal transmission from an infected parent, and of these, 90% of the babies' mothers either use intravenous drugs or had heterosexual partners who were IV drug abusers. (CDC, 1990)

TREND TO PROSECUTE PREGNANT SUBSTANCE ABUSERS PROCEEDS

- To date, over 30 women have been criminally charged for drug use during pregnancy or for delivery of drugs to a minor. A Florida woman has been convicted. Hundreds more pregnant substance abusers have been civilly charged for

alleged child abuse. (American Civil Liberties Union [ACLU], February 1990)

- Four states have amended definitions of child abuse to include drug use during pregnancy (Florida, Illinois, Oklahoma, Rhode Island) and three states have included alcohol and drug use during pregnancy (Indiana, Nevada, Utah); one state amended its definition of criminal child neglect to include prenatal exposure to controlled substances (Minnesota); and three states require doctors to report to the state if either the mother or the child has a positive urine toxicology screen (Minnesota, Oklahoma, Utah). (ACLU, February 1990)

4/19/90

Chairman MILLER. I would like to recognize Mr. Bliley of Virginia.

Mr. BLILEY. Thank you, Mr. Chairman.

I want to begin by commending you for holding these hearings on the consequences of drug abuse on pregnant women and their children.

From the information we have gathered to date, it appears that we are heading for uncharted waters. There are no maps to guide us. It is our job to attempt to survey the relevant medical and legal issues surrounding substance abuse, even though they may conflict with or even threaten some other deeply held positions. Perhaps these hearings will lead us to reconsider those positions also.

We will take the risk, but let me make it clear at the very beginning of these hearings that the delicate balancing act of rights includes both mother and child. We cannot separate our concern for the mother from our concern for the child. Let us also keep our focus and attention on the real issue of alcoholism and the illegal substance abuse which brings us here today.

To attempt to use this issue to immerse ourselves into other areas will invite false solutions. While we face this series of hearings with many questions which need answers, let us review what we do know.

According to a recent voluntary survey, there are 8,689 alcoholism and drug abuse prevention facilities across the 50 states, the District of Columbia and Puerto Rico. In fiscal year 1988, combined state, local and federal expenditures for alcohol and drug abuse treatment and prevention services totaled over $2.1 billion.

Of this $2.1 billion, 77 percent was used for treatment services, 15 percent was used for prevention and 8 percent was used for other activities such as training, research and administration.

State and local governments have taken a leadership role, which has been all too often overlooked. They provided 57 percent of the funds for treatment and prevention, while the federal government and private sources supplied 23 and 20 percent of the funds respectively.

The President's fiscal year 1991 budget seeks $2.7 billion for treatment and prevention, a 75 percent increase over 1989 expenditures. The commitment to preventing and treating substance abuse is substantial. Part of our responsibility must be now to find out whether these treatment strategies are working.

There is an obligation to demonstrate that treatment works both to end abuse during pregnancy and over time. A child's health and development is at stake. For example, there is growing concern that the drug problem may be causing increases in the infant mortality rate. There is widespread agreement that increases in foster care placement are related to drug abuse.

Congress must also be careful not to undermine the effectiveness of local prevention and treatment efforts by imposing federal requirements which will become barriers to treatment. From the information gathered to date no one really knows what works to treat every drug in every situation. There are many differences among the communities served by those 8,689 facilities I mentioned earlier.

For example, some communities have an alcoholism problem, but not a crack cocaine problem. As more money becomes available for treatment, policymakers need to resist the temptation of telling local professionals how to treat clients. Drug abuse is not a condition caused by income or race. It begins as the acting out of envy, pride or anger. Dark clouds of drug abuse spread across neighborhoods and communities because it was too often excused or rationalized by our undisciplined and self-indulgent society.

At the personal level, we must meet anger with justice, jealousy with hope and pain with compassion through the health and welfare service systems. Treatment programs should work with their community organizations, including churches, in this regard. It is clear that successful programs will draw their strength from the community and cannot be uniformly programmed by the federal bureaucracy.

It is everyone's goal to mend the family which was broken by drugs, but we must also recognize that despite the support of dedicated professionals working in the social welfare system, some families cannot withstand the hurricane-force waves of drugs. In some situations local officials must draw the line between the needs of the child and the rights of the parent.

From a policy perspective we must work to insure that due process is safeguarded for the parent and the child, without detrimental effects on the child.

Thank you, Mr. Chairman.

[Prepared statement of Hon. Thomas Bliley follows:]

OPENING STATEMENT OF HON. THOMAS J. BLILEY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA AND RANKING REPUBLICAN MEMBER

Let me begin by commending the Chairman for holding this series of hearings on the consequences of drug abuse on pregnant women and their children. From the information we have gathered to date, it appears that we are heading for uncharted waters. There are no maps to guide us.

It is our job to attempt to survey the relevant medical and legal issues surrounding substance abuse even though they may conflict with or even threaten some other deeply held positions. Perhaps these hearings will lead us to reconsider those positions also. We will take the risk. But let me make it clear at the very beginning of these hearings that the delicate balancing of rights includes both mother and child. We cannot separate our concern for the mother from our concern for the child.

Let us also keep our focus and attention on the real issue of alcoholism and illegal substance abuse which brings us here today. To attempt to use this issue to immerse ourselves into other areas will invite false solutions.

While we face this series of hearings with many questions which need answers, let us review what we do know:

According to a recent voluntary survey, there are 8,689 alcoholism and drug abuse treatment and prevention facilities across the 50 states, the District of Columbia, and Puerto Rico.

In fiscal year 1988, combined state, local and federal expenditures for alcohol and drug abuse treatment and prevention services totaled over $2.1 billion.

Of this $2.1 billion, 77 percent was used for treatment services. 15 percent was used for prevention services and 8 percent was used for other activities such as training, research, and administration.

State and local governments have taken a leadership role which has been all too often overlooked. They provided 57 percent of the funds for treatment and prevention while the Federal government and private sources provided 23 percent and 20 percent of the funds respectively.

The President's Fiscal Year 1991 budget seeks $2.7 billion for treatment and prevention, a 75 percent increase over 1989 expenditures.

The commitment to preventing and treating substance abuse is substantial. Part of our responsibility must be to now find out whether these treatment strategies are working. There is an obligation to demonstrate that treatment works both to end abuse during pregnancy and over time. A child's health and development is at stake. For example, there is growing concern that the drug problem may be causing increases in the infant mortality rate. And there is widespread agreement that increases in foster care placement are related to drug abuse.

But Congress must also be careful not to undermine the effectiveness of local prevention and treatment efforts by imposing federal requirements which will become barriers to treatment. From the information gathered to date, no one really knows what works to treat every drug in every situation. There are many differences among the communities served by those 8,689 facilities I mentioned earlier. For example, some communities have an alcoholism problem but not a crack cocaine problem. As more money becomes available for treatment, policymakers need to resist the temptation of telling local professionals how to treat clients.

Drug abuse is not a conditioin caused by income or race. It begins as the acting out of envy, pride, or anger. The dark clouds of drug abuse spread across neighborhoods and communities because it was too often excused or rationalized by our undisciplined and self-indulgent society.

At the personal level, we must meet anger with justice, jealousy with hope, and pain with compassion, through the health and welfare service systems. Treatment programs should work with their community organizations, including churches, in this regard. It is clear that successful programs will draw their strength from the community and cannot be uniformly programmed by the Federal bureaucracy.

It is everyone's goal to mend the family which was broken by drugs. But we must also recognize that despite the support of dedicated professionals working in the social welfare system, some families cannot withstand the hurricane force waves of drugs. In some situations, local officials must draw the line between the needs of the child and the rights of the parent. From a policy perspective, we must work to insure that due process is safeguarded for the parent and the child without detrimental effects on the child.

ONE HUNDRED FIFTH CONGRESS
GEORGE MILLER, CALIFORNIA
CHAIRMAN
WILLIAM LEHMAN, FLORIDA
PATRICIA SCHROEDER, COLORADO
LEON E. PANETTA, CALIFORNIA
MATTHEW G. MARTINEZ, CALIFORNIA
TED WEISS, NEW YORK
JOHN J. BRADEMAS, INDIANA
BARBARA BOXER, CALIFORNIA
SANDER M. LEVIN, MICHIGAN
JAMES H. MORRISON, CONNECTICUT
J. ROY ROWLAND, GEORGIA
TOM LANTOS, CALIFORNIA
ALAN WHEAT, MISSOURI
MATTHEW G. MARTINEZ, CALIFORNIA
LANE EVANS, ILLINOIS
RICHARD J. DURBIN, ILLINOIS
DAVID E. SKAGGS, COLORADO
BILL RICHARDSON, NEW MEXICO

KATHERINE PRIDEMOTE
STAFF DIRECTOR
JILL D. KAGAN
DEPUTY STAFF DIRECTOR

TELEPHONE: 226-7020

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
385 HOUSE OFFICE BUILDING ANNEX 2
WASHINGTON, DC 20515

THOMAS J. BLILEY, JR., VIRGINIA
RANKING MINORITY MEMBER
FRANK R. WOLF, VIRGINIA
BARBARA F. VUCANOVICH, NEVADA
DAN PACKARD, CALIFORNIA
J. DENNIS HASTERT, ILLINOIS
JIM C. HOLLOWAY, LOUISIANA
CURT WELDON, PENNSYLVANIA
LAMAR S. SMITH, TEXAS
PETER SMITH, VERMONT
JAMES T. WALSH, NEW YORK
RONALD K. GINGRICH, RHODE ISLAND
TOBY ROTH, WISCONSIN
CHRIS H. SMITH
MINORITY STAFF DIRECTOR
CHARLES G. STENHOLM
MINORITY COUNSEL STAFF DIRECTOR

TELEPHONE: 225-7202

BEYOND THE STEREOTYPES: WOMEN, ADDICTION, AND PERINATAL ABUSE

Minority Fact Sheet

April 19, 1990

CONTENTS

No Consensus on the Extent of the Problem.....13
Degree of Harm to the Newborn Child--Unknown....13
Maternal Substance Abuse and Birth Outcome.....14
Emerging Data on the Long-term Developmental
Effects of the Newborn Child is Limited....16
Profile of Substance-abusing Mothers.....17
Funding of Federal Drug Control Programs.....18
Funding of Prevention and Treatment Activities..19
Targeting Resources to Women.....20
State and Local Prevention and Treatment
Expenditures.....22
Private Sector Efforts.....22

Prepared by:

Cathy Caridi, Cathy Deeds, D. Jeffrey Hollingsworth

FACTS AND FINDINGS

NO CONSENSUS ON THE EXTENT OF THE PROBLEM

o The National Institute on Drug Abuse (NIDA) estimates that over 5 million women of child bearing age are using illegal substances; including 1 million women of child bearing age on cocaine. (Crack Babies, Office of the Inspector General, DHHS, February 1990, p. 1.)

o The Office of National Drug Control Policy estimates that 100,000 "crack babies" are born each year. (National Drug Control Strategy, The White House, January 1990, p. 32.)

o In a study of 36 hospitals from around the country, the overall incidence of substance abuse in pregnancy was 11% with a range from 0.4% to 27%. Extrapolating from the 3,809,000 live births in the United States as a whole, this implies that 375,000 drug-addicted infants are born each year. (see Ira Chasnoff, "Drug Use and Women: Establishing a Standard of Care," Annals of the New York Academy of Sciences, June 30, 1989, p. 208.)

o No one knows how many crack babies there are. A national total of 1 or 2 percent of all live births, or 30,000 to 50,000 crack babies, seems a realistic figure. (Doug Besharov, "The Children of Crack: Will We Protect Them?" Public Welfare, Fall 1989, p. 7.)

DEGREE OF HARM TO THE NEWBORN CHILD--UNKNOWN

o No study of children's outcomes published to date has adequately controlled for the amount of drug use, the intensity of drug use, the frequency of drug use, and the type of drug use. (Richard P. Barth, "Educational Implications of Prenatally Drug Exposed Children," Social Work in Education, in press.)

o There is no information regarding the relationship of patterns of cocaine use in pregnancy and differential effects on outcome of pregnancy and the newborn infant. A 1986-88 study at Northwestern University found that the weight, length, and head circumference of infants whose mothers used cocaine only in the first trimester were not significantly reduced from that of drug-free control infants. (Ira Chasnoff, Dan Griffith, Scott MacGregor, Kathryn Dirkes, Kayreen Burns, "Temporal Patterns of Cocaine Use in Pregnancy: Perinatal Outcome," JAMA, March 1989, pp. 1741, 1743.)

o The effects of cocaine on pregnancy in human beings are uncertain. A 1983-84 study at Northwestern University found that the neonatal gestational age, birth weight, length, and head circumference of infants of cocaine-using women were not affected by cocaine use. (Ira Chasnoff, William Burns, Sidney Schnoll, Kayreen Burns, "Cocaine Use in Pregnancy," New England Journal of Medicine, September 1985, pp. 666, 668.)

o Despite considerable knowledge of cocaine's effects on the adult user, information regarding the outcome of infants exposed to cocaine in-utero is available only in limited numbers of infants. [Lynn Ryan, Saundra Ehrlich, Loretta Finnegan, "Cocaine Abuse in Pregnancy: Effects on the Fetus and Newborn," Neurotoxicology and Teratology, 1987, p. 295.]

o The long-term effects of prenatal drug exposure on the cognitive, social and emotional development of children remain undetermined. [Carol Rodning, Lolis Beckwith, Judy Howard, "Attachment and Play in Prenatal Drug Exposure," in press.]

o At this point in time, we do not have definitive information about the futures of perinatally drug-exposed children. Research tells us little about long-term outcomes, but strongly suggests that children may be affected quite differently by their prenatal and postnatal experience. [Richard P. Barth, "Educational Implications of Prenatally Drug Exposed Children," Social Work in Education, in press.]

o Some reports are suggesting that drug-affected children are a class of children unlike anything we have ever seen. Yet, these children vary greatly from each other and are probably far more like other children who have suffered prenatal and environmental insults than they are different. [Barth, Press release from UC Berkeley, March 12, 1990, p. 2.]

MATERNAL SUBSTANCE ABUSE AND BIRTH OUTCOMES

o Although the exact distribution of (a) drug between maternal and fetal circulation is difficult to determine, drugs with high abuse potential (e.g., opiates, cocaine, sedative-hypnotics, alcohol, and stimulants) are found in the fetus if the mother is using or abusing these drugs. [Ira Chasnoff, "Drug Use in Pregnancy: Parameters of Risk," The Pediatrics Clinics of North America, Dec. 1988, p. 1404.]

Marijuana

--Abnormalities of the nervous system, interpreted as immaturity and disruptions of fetal sleep patterns
--Decreased birth weight, length, head circumference
--Increased incidence of stillbirth and neonatal mortality
--Use by mother near time of delivery can prolong or shorten labor and delivery due to effects on infant behavior
--Withdrawal

[Caryl LaRue Jones, Ph.D., and Richard E. Lopez, Ph.D., "Component Report on Drug Abuse: Direct and Indirect Effects on the Infant of Maternal Drug Abuse," in Public Health Service Report on the Content of Prenatal Care, Vol. II, DHHS, in press.]

Cocaine

--irritability, hyperreflexia, tremulousness
--decreased birth weight, length, head circumference
--Neonatal neurobehavioral dysfunction
--Congenital anomalies: cardiac, genitourinary, and limb

malformations
--Visual and auditory dysfunction
--Seizures which might indicate cerebral palsy or mental retardation
--Long-term developmental neurobehavioral disabilities
--Withdrawal
--Increased incidence of spontaneous abortion
--Sudden Infant Death Syndrome (SIDS) [Caryl LaRue Jones, Ph.D., and Richard E. Lopez, Ph.D., "Component Report on Drug Abuse: Direct and Indirect Effects on the Infant of Maternal Drug Abuse," in Public Health Service Report on the Content of Prenatal Care, Vol. II, DHHS, in press; Lynn Ryan, Saundra Ehrlich, Loretta Finnegan, "Cocaine Abuse in Pregnancy: Effects on the Fetus and Newborn," Neurotoxicology and Teratology, Vol. 9, 1987; Gilberto Chavez, Joseph Mulinare, Jose Cordero, "Maternal Cocaine Use During Early Pregnancy as a Risk Factor for Congenital Urogenital Anomalies," JAMA, August 1989, p. 795; Diana Petitti and Charlotte Coleman, "Cocaine and the Risk of Low Birth Weight," AJPH, January 1990, p. 25.]

Opioids (Narcotics)

Heroin, Morphine, Opium
--Lower birth weight
--Mental and neurological deficiencies
--chromosomal breakage and aberration
--Drug-induced respiratory depression
--Vascular changes
--Narcotic withdrawal syndrome: hyperactivity, respiratory distress, fever, diarrhea, mucus secretion, sweating, convulsions, yawning and face scratching [Caryl LaRue Jones, Richard Lopez, "Component Report on Drug Abuse: Direct and Indirect Effects on the Infant of Maternal Drug Abuse," in Public Health Service report on the Content of Prenatal Care, Vol. II, DHHS, in press.]

Methadone
Methadone-exposed newborns are significantly smaller in weight and length compared to drug-free infants through 6-9 months of age, but usually catch up in weight and length by 12 months. The one exception is that of head circumference: it does not exhibit catch-up growth. Small head size in young infants has been reported to be predictive of poor developmental outcome. [Ira Chasnoff, "Drug Use in Pregnancy: Parameters of Risk," The Pediatrics Clinics of North America, Dec. 1988, p. 1406.]

Phencyclidine (PCP)

--Withdrawal, including tremors, irritability, hypertonia
--Sudden outbursts of agitation, rapid changes in level of consciousness, bizarre eye movements, sleeplessness
--Vomiting, diarrhea
--Respiratory distress
--Spasticity
--Cerebellar malformation
--Increased risk of prematurity and lower birth weight [Caryl LaRue Jones, Richard Lopez, "Component Report on Drug Abuse: Direct and Indirect Effects on the Infant of Maternal Drug Abuse," in Public Health Service report on the Content of Prenatal Care, Vol. II, DHHS, in press; Arthur Strauss, Houchang Modanlou, Sogbe Bosu, "Neonatal Manifestations of Maternal Phencyclidine (PCP) Abuse," Pediatrics, October 1981, p. 550; Nancy Golden, Robert Sokol, I.Leslie Rubin, "Angel Dust: Possible Effects on the Fetus," Pediatrics, January 1980, p. 18.]

Alcohol

o For pregnant women who consume three drinks of alcohol per day, there is a 10 percent chance that their babies will be born with the Fetal Alcohol Syndrome (FAS). The risk rises to 33 percent if the mother imbibes six drinks per day. The risk rises as the dose increases. (Robert DuPont, Getting Tough on Gateway Drugs, Washington, DC: American Psychiatric Press, Inc., 1984, p. 111)

o Fetal Alcohol Syndrome has not been reported in children of "social-" or "moderate-" drinking women. It has become apparent that children severely affected by Fetal Alcohol Syndrome are born to only those mothers who consume large amounts of alcohol daily during pregnancy. (DHHS, Report to the U.S. Congress on Alcohol and Health, 1988, p. 221-2.)

EMERGING DATA ON THE LONG-TERM DEVELOPMENTAL EFFECTS OF THE NEWBORN CHILD IS LIMITED

o A UCLA study of 18 month old toddlers prenatally exposed to a variety of drugs suggests both physiological and behavioral effects of prenatal exposure. Prenatal drug-exposure appears to have an adverse effect on developmental processes that extends beyond the newborn and early infancy period. Drug-exposed toddlers demonstrated significantly lower intellectual functioning than a drug-free comparison group. Dramatic deficits were seen in the drug-exposed children's spontaneous play where self-initiation, organization, and follow-through without the assistance of the examiner to guide the tasks, were called for. (Carol Rodning, Lelia Beckwith, Judy Howard, "Attachment and Play in Prenatal Drug Exposure," in press.)

o A review of five longitudinal studies which evaluated methadone-exposed infants throughout their first two years suggests that no long-term developmental sequelae are directly associated with methadone exposure in-utero. (Karol Kaltenbach and Loretta Finnegan, "Developmental Outcome of Children Born to Methadone Maintained Women: A Review of Longitudinal Studies," Neurobehavioral Toxicology and Teratology, 1984, p. 271-274.)

o A New York City study found neurobehavioral deficits in children of methadone-treated mothers at 18 months of age which may be predictors of later learning and behavioral problems. (Tove Rosen, Helen Johnson, "Children of Methadone-Maintained Mothers: Follow-up to 18 Months of Age," Journal of Pediatrics, August 1982, p. 192.)

o The most recent findings from a Seattle longitudinal study show that alcohol-related neurological and behavioral effects have persisted in the children of the heavier-drinking mothers to at least 4 years of age. (DHHS, Report to the U.S. Congress on Alcohol and Health, January 1987, p. 86.)

o A ten-year followup study of adolescents who were born with the fetal alcohol syndrome indicates that its effects are permanent. The correlation between severity of mental retardation and severity of physical deformity and growth deficiency has

persisted into adolescence. (DHHS, Report to the U.S. Congress on Alcohol and Health, January 1987, p. 99.)

o The best studies show that children exposed to drugs before birth may still have intelligence in the normal range. They may also have a range of other atypical cognitive and gross motor characteristics. (Richard P. Barth, "Educational Implications of Prenatally Drug Exposed Children," Social Work in Education, in press.)

PROFILE OF SUBSTANCE-ABUSING MOTHERS

o Rhode Island completed a survey of hospital admissions in October and November 1989 to measure the statewide prevalence of illicit drug use by pregnant women. Findings:

--Specimens for 35 (7.5%) of the 465 women were positive for at least one drug.

--Women with public insurance were four times more likely to be positive (16.1%) than were women with private insurance (4.1%).

--Cocaine was detected more commonly in women who were other than white (8.2%), used public insurance (8.9%), were classified as living in poverty (6.8%), had one or more children (4.2%), and delivered at the regional perinatal center (3.9%). Women who were using public insurance were also more likely to be positive for marijuana (5.6%).

(CDC, "Statewide Prevalence of Illicit Drug Use by Pregnant Women - Rhode Island", MMWR 1990; Vol. 39, No. 14 pp. 226, 227. Reported by: LM Hollinshead, MD, JF Griffin, MPH, MD Scott, MD, ME Burke, MSW, Office of Data and Evaluation, Div of Family Health, Rhode Island Dept of Health; DM Causten, MD, Rhode Island Medical Society; TA Vest, MD, American College of Obstetricians and Gynecologists--Rhode Island Section.)

o Most crack mothers are not teenagers. Most often, they are between their early 20s and 30s, with an average age of 25 to 28 years. Usually, they have between two and four other children. Crack babies reported to the child welfare system are primarily black, with a smaller number of Hispanics and even fewer whites. (Crack Babies, Office of the Inspector General, DHHS, February 1990, p. 1.)

o A 1984 Boston City Hospital study of pregnant women found that cocaine users were more likely to be single and born in the United States than nonusers, and were less well nourished. (Deborah Frank, Barry Zuckerman et al, "Cocaine Use During Pregnancy: Prevalence and Correlates," Pediatrics, Dec. 1988, p. 888.)

o Marijuana and snorted cocaine are more prevalent among middle and upper income women, while crack and heroin use are more often found in low income women. (Laura Feig, "Drug Exposed Infants and Children: Service Needs and Policy Questions," ABPH, January 29, 1990, p. 3.)

o A Boston City Hospital study found that among adolescents, pregnant drug users were more likely to be black, have a history of abortion and venereal disease, report more negative life events

and violence during pregnancy, and receive more support from the father of the baby who was more likely to use marijuana and cocaine. (Hortensia Amaro, Barry Zuckerman, Howard Cabral, "Drug Use Among Adolescent Mothers: Profile of Risk," Pediatrics, July 1989, p. 144-150.)

o Drug use can supercede all other aspects of the lives of crack addicted mothers. In the words of one caseworker, working with the mothers "is like beating your head against a brick wall...because you are dealing with someone who has no control over her life. She's worried about her next hit." Caseworkers can spend days tracking mothers who give false addresses to hospitals and then abandon their babies. (Crack Babies, Office of the Inspector General, DHHS, February 1990, p. 1.)

o "The most remarkable and hideous aspect of crack cocaine use seems to be the undermining of the maternal instinct. Last year, an addicted mother in Oakland was found to have smoked crack at home during labor and between the delivery of twins, both of whom later died. This type of behavior indicates total obsession and extraordinary chemical dependence." (Prepared testimony of Sue Tripin, R.N., cited in "Born Hooked: Confronting the Impact of Perinatal Substance Abuse," a Hearing before the House Select Committee on Children, Youth, and Families, Washington, DC, April 11, 1989, p. 156.)

FUNDING OF FEDERAL DRUG CONTROL PROGRAMS

o Spending for all Federal drug control programs has grown from $1.4 billion for both outlays and budget authority in 1981 to a proposed FY 1991 level of $10.6 billion in budget authority. The President's FY 1991 request represents an increase of 12 percent.

FEDERAL DRUG CONTROL BUDGET
(in billions of dollars)

	1981	1983	1985	1987	1989	1990*	1991*
Budget Authority	1.4	1.9	2.6	4.6	8.3	9.5	10.6
Outlays	1.4	1.8	2.4	3.6	5.6	6.9	9.7

* estimates

(Budget of the United States Government, Fiscal Year 1991, Section III.E., p. 111.)

FEDERAL DRUG CONTROL ACTIVITIES
(budget authority in millions of dollars)

	FY1989	FY1990	FY1991	FY90-91	Increase
Criminal Justice	$2,682	$4,191	$4,279	$ 88	2%
Treatment	888	1,337	1,492	155	12
Education, Community Action, & The Workplace	677	1,118	1,242	124	11
International Activities	304	419	690	271	65
Interdiction	1,467	2,029	2,373	344	17
Research	231	318	383	65	20
Intelligence	53	71	172	101	142
TOTAL	$6,302	$9,483	$10,631	$1,148	12%

FUNDING OF PREVENTION AND TREATMENT ACTIVITIES

o Two dozen Departments, agencies and sub-agencies spent $1.6 billion on treatment and prevention activities in 1989. The FY 1991 President's budget request seeks $2.7 billion. The following table provides a breakdown of the agencies which have responsibility for prevention and treatment:

NATIONAL DRUG CONTROL BUDGET
(Budget authority in millions of dollars)

Drug Abuse Prevention	1989 actual	1990 estimate	1991 request
ONDCP	1.2	4.0	5.5
Special Forfeiture Fund	0.0	0.0	0.0
ADAMHA	120.8	234.5	282.9
Centers for Disease Control	20.0	25.2	30.2
Human Development Services	30.0	29.6	29.6
Family Support Administration	3.0	1.9	0.0
Dept of Defense	69.7	72.5	74.6
Education	354.5	539.2	593.3
Housing and Urban Development	4.1	49.2	75.0
Labor	38.2	70.1	83.5
Bureau of Land Management	0.1	0.3	0.3
National Park Service	0.2	0.4	0.4
Bureau of Indian Affairs	2.6	5.7	6.9
Office of Ter. & Intntal. Affairs	0.0	0.2	0.4
ACTION	10.1	9.2	9.6
Agency for International Development	3.1	4.7	3.4
DEA	2.2	2.2	2.2
Office of Justice Programs	13.0	56.6	30.8
Federal Aviation Admin.	4.3	12.6	13.2
PREVENTION SUBTOTAL	677.1	1,118.1	1,241.8

Drug Abuse Treatment

ONDCP	1.2	4.0	5.5
Special Forfeiture Fund	0.0	0.0	0.0
ADAMHA	391.7	685.6	759.7
Health Care Financing Admin.	140.0	170.0	190.0
Indian Health Services	18.7	32.8	33.0
Human Development Services	0.0	0.0	6.0
Education	21.8	23.3	24.4
Depart. of Defense	12.4	11.6	11.4
Bureau of Prisons	4.1	6.0	8.0
Office of Justice Programs	34.4	95.1	104.9
Bureau of Indian Affairs	0.0	0.0	0.0
Labor	0.4	0.5	2.7
Veterans Affairs	239.8	269.2	297.7
U.S. Courts	23.3	39.2	48.5
TREATMENT SUBTOTAL	887.8	1,337.3	1,491.8
TOTAL PREVENTION AND TREATMENT	$1,564.9	$2,455.4	$3,733.6

(National Drug Control Strategy, Budget Summary, p. 12. The White House, Washington: January 1990)

o Since FY 1987, support for all HHS anti-drug abuse initiatives has increased from less than $400 million to $1.7 billion requested in the FY 1991 President's budget." (The "Fiscal Year 1991 Budget", U.S. Dept. of Health & Human Services, Washington, p. 8.)

TARGETING RESOURCES TO WOMEN

o The Alcohol-Drug Abuse-Mental Health Services (ADAMHS) Block Grant set-aside for substance abuse programs and services for women has expanded eight-fold since 1985, rising from 3% by law of all funds, or approximately $14.7 million, to 10%, or approximately $119.3 million, of the $1.2 billion contained in the block grant for FY 1990. ("The Fiscal Year 1991 Budget", DHHS, p. 32; Office of Treatment Improvement, ADAMHA.)

o "In Fiscal Year 1991, the Federal government will devote additional resources to pregnant addicts and their children through outreach, treatment and research. Through proposed State treatment action plans, States will be held accountable for providing improved and expanded outreach efforts and treatment programs for pregnant addicts. (The Office of Substance Abuse Prevention) will award grants...to support demonstration programs on prevention, education, and early intervention...(The National Institute on Drug Abuse) will (support) demonstration grants for research and development of outreach as well as safe and efficacious treatment services to pregnant addicts...(T)he Administration will support further research and data collection to improve our understanding

of the nature and extent of this problem." (National Drug Control Strategy, p. 32)

o "(S)ervices to women with alcohol and drug problems have increased significantly due to the availability of funds for new and expanded programs, as well as the cumulative effects of the previous years' efforts on behalf of this target population. Through establishment of child care components, a significant barrier to many women's participation in treatment (has been) overcome in numerous States." (ADAMHA Block Grant Set-Aside Report to Congress, Fiscal Year 1989 and Fiscal Year 1990, p. 4. Washington, D.C.: ADAMHA, 1990.)

o "Approximately $200 million (will be provided this year) for treatment programs directed at adolescents, pregnant women and infants, in addition to treatment 'campuses' and treatment evaluation and referral programs." (National Drug Control Strategy, Executive Summary, p. 3, Jan. 1990.)

o An estimated $170 million will be spent by Medicaid in FY1990 for drug treatment costs, up from $140 million in outlays in FY 1989. (National Drug Control Strategy Budget Summary, op. cit., pp. 189-90.)

o The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) of the Department of Health and Human Services (HHS) spent $48.5 million in FY 1989 on programs and research concerned with drug abuse exclusively among pregnant women, excluding block grant funds. An additional $7.2 million was spent for research on alcoholism and women. It will spend a projected $110.3 million in FY 1991. The following table provides additional details:

DRUGS AND PREGNANT WOMEN

Activity	FY1989	FY1990 Est.	FY1991	Est.89-91 +/-
NIDA Research	$13,780	$20,900	$23,900	73.4%
NIDA Demos.	18,445	25,500	26,000	41.0%
Subtotal NIDA:	32,225	46,400	49,900	54.8%
OSAP Demos.	5,145	35,049	42,844	732.7%
OTI Demos.	11,250	20,046	17,648	56.9%
TOTAL:	$48,620	$101,505	$110,392	127.1%

Note: NIDA--National Institute on Drug Abuse
OSAP--Office of Substance Abuse Prevention
OTI--Office for Treatment Improvement
(ADAMHA Division of Financial Management; HHS Office of Asst. Secretary for Management & Budget)

o The ADAMHS Block Grant, which provides 17% of all funds used by states for alcohol/drug abuse services, was changed by the Anti-Drug Abuse Act of 1988 to increase the set-aside for women from 5%

of all funds to "not less than 10 percent for programs and services designed for women (especially pregnant women and women with dependent children) and demonstration projects for the provision of residential treatment services to pregnant women." (Public Health Service Act, Part B, Sec. 1916 (c)(14), p. 495.)

o The HHS Office of Human Development Services (OHDS) will spend an estimated $29.6 million in FY1990 "for drug-related prevention activities, including...projects that will prevent the abandonment of infants, identify and address their needs, and conduct early intervention, education and diversion of at-risk, runaway, and homeless youth." (National Drug Control Strategy Budget Summary, op. cit., p. 138.)

o "An additional $6 million is requested [in FY1991] for the [OHDS] Child Welfare Research and Demonstration program to coordinate medical and social services and increase access to a wide range of comprehensive services for drug-dependent ('crack babies') and HIV infected children." (Ibid., p. 137.)

STATE AND LOCAL PREVENTION AND TREATMENT EXPENDITURES

o In FY 1988, state governments provided $1.02 billion for alcohol and drug abuse prevention and treatment services. Local governments contributed $191.3 million. Together, state and local governments provided 57 percent of all alcohol and drug abuse treatment and prevention services expenditures. (National Association of State Alcohol and Drug Abuse Directors, Inc. State Resources and Services Related to Alcohol and Drug Abuse Problems. Washington: June 1989 p. 1.)

PRIVATE SECTOR EFFORTS

o Nearly $103 million for 1,800 grants from more than 400 foundations (private, corporate, community, etc.) has been given between 1980 and 1987 to support alcohol/drug abuse prevention, treatment, research and education projects. Foundation giving for these purposes increased sixfold between 1980 and 1987 and came from more foundations than ever before. (Loren Renz, Alcohol & Drug Abuse Funding: An Analysis of Foundation Grants, pp. 13, 15. New York, N.Y.: The Foundation Center, 1989.)

o In FY 1987 (the latest figures available), private foundations gave away $26.36 million in current dollars to support alcohol/drug abuse programs. The figure in constant dollars equals $23.20 million. For the first time, prevention grants ($13.7 million or 51.7%) exceeded intervention grants ($9.9 million or 37.4%). (Renz, op. cit., pp. xii, 13.)

o As of 1988, 87% of employee-based group health insurance plans provided acute-care benefits of various kinds for substance abuse. Substance abuse coverage was offered by 97% of preferred-provider organization (PPO) plans and by 98% of health maintenance organizations (HMOs). (The Health Insurance Picture in 1988, p. 7. Washington, D.C.: Health Insurance Association of America (HIAA).)

Chairman MILLER. Congressman Hastert.

Mr. HASTERT. I certainly want to thank the chairman for bringing this issue before the committee and certainly before the Congress.

As we've heard this morning, drug abuse, and especially the use of like crack cocaine and alcohol cuts across economic, social, religious, ethnic and racial boundaries.

When that happens we need to have concern for the parents, and especially mothers, most importantly we need to have concern for the children because they are the ones who have their future before them. In some instances they're starting out life with two strikes against them.

So we need to make sure that we just don't broad-brush this issue, because every community, every state, every city certainly is different. They have different needs and different concerns. We need to give those people who are the providers on that local level the tools, they need especially to start to help salvage the children from this type of situation and to make sure that they have a bright and hopeful future.

So thank you, Mr. Chairman for bringing this to our attention.

Chairman MILLER. Mr. Martinez.

Mr. MARTINEZ. Thank you, Mr. Chairman.

The problem that we have is that this is "nobody's" problem. We have to understand that environments, whether it's a middle class environment or a very poor environment, most of it I have seen has come out of the poor environment where the hopelessness of that environment and the influences and the frustration of that environment are what—with no choice and no alternative—led to those problems there.

That still exists, whether it's a poor society or a little more affluent society, in the minds of people who are in a situation which they cannot deal with or cope with and they turn to that. Those are the things that we have to provide answers to, and how we deal with those particular individuals that feel they can't cope. Enough education centers, enough centers where people can go for help, enough money spent there.

We can put a man on the moon and we can build planes like the JVX Tilt Rotor back there and that space shuttle launch, still we can't devote enough commitment or time to our own people, the people that need it. I commend you for these hearings and I hope that the result of these hearings is to come to understand and realize what the problems really are and how they fester and how we're going to do something about it.

Thank you, Mr. Chairman.

Chairman MILLER. Thank you. Mrs. Boggs, is there a statement you'd like to make?

Mrs. BOGGS. Thank you, Mr. Chairman, very much. Thank you for convening this hearing. It's very, very necessary to hold this hearing. Tomorrow I'll be going down to Florida to an infant mortality conference. Our dedication in this committee, I think, should be focused on the problem that we're addressing today.

It was very encouraging to discover that there has been some very significant work on identifying a gene that may be responsible

for alcohol addiction generation to generation, and certainly that is a great step forward.

I might say, Mr. Martinez, that many of the fallouts, if you will, of the space program have been in medical research, medical treatment, the kinds of products that are very helpful in all of those regards. So that whatever we do in research and whatever we do in the development of it, really bears on the problem that we're addressing today.

It's an extraordinarily important problem and I congratulate the chairman and the committee staff, and all the people who will be participating for holding it.

Thank you.

Chairman MILLER. Thank you. With that we'll begin to hear from our first panel, which will be made up of Kathleen, who is a parent from Germantown, Maryland; Dr. Reed Tuckson, who is the senior vice president for programs in the March of Dimes Birth Defects Foundation; Douglas Besharov, who is a resident scholar, American Enterprise Institute; and Dr. Sheila Blume, who is the medical director of the Alcoholism, Chemical Dependency, Compulsive Gambling Program of South Oaks Hospital of Amityville, New York.

Come forward, please. We'll recognize you in the order in which you're listed and that I called you. Welcome to the committee. Your written statement will be placed in the record in its entirety, and any supporting documentation that you have. I want you to proceed in a manner which you are most comfortable and we look forward to your testimony and we thank you for taking your time to be with us.

Kathleen, we're going to start with you. Welcome.

Ms. "X". Hi.

Chairman MILLER. Let me just say that I'm sorry we don't have enough chairs in the committee room, but if people want to come up here, if some of you want to sit down on the floor, you're more than welcome to, whatever you'd like to do to make people come into the room, please feel free to do so.

We're a pretty casual committee, so just hang out. We'll make a deal with you, you're more than welcome to sit in the front row here unless we get so many members of Congress, but we're not going to allow you to ask questions now. You're more than welcome to take a seat up here if you're not comfortable down in front. [Laughter.]

STATEMENT OF KATHLEEN "X", PARENT, GERMANTOWN, MD

Ms. "X". Hi. My name is Kathleen, and I am recovering from the disease of chemical dependency. I've believed for quite a while now this disease is genetic. It runs in both sides of my family. There is a joke, my mother is Irish and my father is part Indian, so someone told me I didn't have a chance from the beginning.

Anyway, today I work in the field of addiction. I am regional director of marketing for a treatment center, Mountain Manor, and we have a women's and children's program. I also sit on the Alcohol Advisory Board in Montgomery County, active on the credentialing board, I'm a certified addictions counselor.

A little over six years ago I lived in Washington, D.C., I was on welfare, I was on a methadone maintenance program over at D.C. General Women's Services Clinic, and pretty much went from place to place, car to car, really had no direction and no goal. I was emotionally, physically and spiritually very ill.

I'd like to share just a little bit about my background. I was a kid in Montgomery County, attending school, I was an A/B student. I was raised in an alcoholic home. I went to church a lot, my mom took us to church, and my dad owned bars. Drinking was very normal in my family.

I like to think today that I ended up where I ended—it was a combination of a genetic predisposition with social permission. I began drinking very early on. I left home very young, my home life had the appearance of a "Leave it to Beaver" type of home, it was a beautiful house and a country club. Inside the rooms, you know, it didn't look what it appeared to be.

Today I know that my parents were victims of the way that they were raised, victims of the disease of alcoholism, and that they are really good people. My dad was real sick and my mother became real sick trying to control his drinking and dealing with her grief and pain around his alcoholism.

There were seven children. Like I said, I left home when I was 15. I had been using drugs by the time I was 15. I became pregnant and married a drug addict who was 19. I had two children by the time I was 18, I was on welfare, I had dropped out of school in tenth grade.

I want to keep it fairly brief. My child today who is now 17, Carly, has fetal alcohol syndrome. What would happen for me is when I became pregnant I would stop using the illegal drugs, because in my mind I said I can't shoot heroin anymore, I can't use LSD, so I would drink white wine.

My disease had not progressed at that point to the point where I was a maintenance drinker or a daily drinker, but I did drink wine. Back then nobody really said that there was anything wrong with that. My child was misdiagnosed for years, I just took her to Georgetown Developmental Clinic. Actually, I had diagnosed her myself, because with working in the field I started reading and researching and I had thought that she had all the symptoms of fetal alcohol syndrome.

I went on, I had another child with that marriage who is here with me today, Erin, she has written testimony that will be entered today.

I left that marriage believing that my problem was this man who was an addict, married another addict. All these behaviors are very typical and very predictable. I know that today, I didn't then. I believed that I had to use because I had so many problems in my life, I had so many tragedies. This child was a burden, I had dropped out of school, all these things.

I didn't know that I was using because I was addicted and that there was treatment. As my disease progressed, I came to loathe myself. I remember feeling so confused because I had this tremendous love for my kids, and I would tell myself that I'm not going to use today, I'm not going to use anything. I would get up and I would make promises to the children, and I would tell them,

"Mommy is not going to drink any more wine. Mommy is not going to eat any more valiums and this kind of thing," but I could never keep those promises.

Day by day my self-esteem just got worse and worse and worse, and I just started to really believe that I was a bad person. I remember just feeling so confused. Why did my behavior not reflect the love I felt for these kids. I really didn't care about myself at that point. I really believe today that being raised in the environment that I was, and this is not to blame parents, it's just to say that I say that I understand the disease and how it affects the family, that I wasn't given the nurturing and support that I could have been if my parents were healthier.

Anyway, I remarried another addict, very typical again of someone with co-dependency and addiction. I had two other children, and I can look and I can say that is so insane to have two more children when I had three children that I couldn't even take care of. What was I doing? I can understand today I was trying to fix my life through externals. I kept thinking if I have another child it's going to force me to pull my life together because I didn't understand the disease of addiction.

I had two more children. My fourth child died when he was two days old, he was born prematurely due to my addiction. My fifth child died from sudden infant death syndrome when she was almost three months old.

You know, we can look and we can watch the news and watch these people having these babies, these crack babies, and what an awful thing. Why would they have these children if they're addicted? Let me tell you, when you're caught up in the disease of addiction you don't know how sick you are. There's something called denial that goes along with the disease.

I never wanted to harm anybody, I just wanted to fix my life. My children were the motivating factor for me to get into recovery. I went through a lot. After my child died from sudden infant death, I became very depressed. I ended up—my mother took my children and watched them, because I just became very suicidal and really gave up on life.

I got into treatment, I did go through Mountain Manor where I work today. I went through treatment, and I went through 30 days. After treatment they had nowhere to send me and I went back home. Let me tell you, after years of being on narcotics and alcohol and to go back home, I didn't have a high school diploma, I had never really held a job other than bartending or waitressing, and I didn't have any friends, I didn't know how to live sober.

I ended up using again and volunteered for a long term program. The only program that was available in Montgomery County at the time, Second Genesis. I'm very grateful that I went through that program, although some of their beliefs are not my beliefs.

It's a punitive model of treatment, I found. I was called names, I had to wear toilet paper around my neck for being a person. The belief there was, I guess, that if you change the behavior that it would stop the addiction, although I felt that I knew I had a genetic disease and that I was a good person and that I needed to be somewhere.

Today I've been sober going on six years and do work with women and children, and I feel that I'm an advocate for children. I volunteer and run a group over at Mark Twain School in Montgomery County. Most of these kids live in, also, abusive addicted households and are substance abusers themselves.

My son is 18, he's a student at West Virginia University. My daughter Carly lives at home with us and she's doing really well. She's in a real supportive, loving environment. Erin is real courageous. They're supportive of me because we understand that this is a disease.

I guess if I get one message across, people that are suffering from the disease of addiction are not bad people. When we talk about women and children, these women need love and nurturing and understanding and a safe place to be. They need skills to make it out there. I've been very fortunate that I was loved until I could love myself.

I just would like to thank everybody here for listening to me today. Thank you.

[Prepared statements of Kathleen and Erin "X" follow:]

PREPARED STATEMENT OF KATHLEEN X, GERMANTOWN, MD

I am recovering from the disease of chemical dependency; my name is Kathleen. I hope that my story of addiction and recovery will help the Select Committee understand the need for treatment, not punishment.

I was raised in Montgomery County, MD in an upper class home, attended parochial school, with an above average IQ. My dad was a "functioning alcoholic," and my mother was extremely co-dependent on my father, that is her life completely revolved around him and his alcoholism to the point where she couldn't take care of herself anymore. As his disease progressed and worsened, so did her codependency. There were many secrets in our home.

All 7 children went through physical, mental and emotional abuse and negligence, as neither parent was able to provide us with the emotional support and nurturing for healthy self-esteem. Today I realize that both my parents were sick, not bad.

Research shows us that this disease is genetic. I was certainly predisposed, that is, if I used chemicals I would become addicted. Plus, before I ever used, or "picked up", I had no self-worth, truly a victim of my environment.

I naturally was drawn to a negative crowd of youngsters, like me from alcoholic homes, who were experimenting with drugs themselves. I finally fit in! I became sexually active (another predictable behavior), got pregnant and left home at 15 to move in with my 19 year old, drug-addicted husband.

That marriage lasted 10 years, we had three children. I would stop using "hard drugs" when I became pregnant, and would substitute legal drugs like alcohol, or just smoke a little pot. In my mind, those drugs were mild and O.K. to use. My 17 year old daughter is a victim of that legal drug use. Today, she suffers from Fetal Alcohol Syndrome, directly resulting from alcohol use.

Today I know that one of the symptoms of the disease is an inability to stop using, or loss of control. So what pregnant addicts do is minimize, substitute, do more lying and hiding. If they can control drugs, they do not have the disease.

I tried everything to pull my life together. I didn't realize that drugs and booze were the problem--I thought I used chemicals <u>because</u> I had so many problems. I decided that my husband was the problem, so I left him. By the time my son was 13, he had attended 16 different schools. I tried to fix my life through externals.

The most painful memory I have of my addiction is the tremendous guilt and shame I experienced around my children. I have to remind myself that I was also a victim myself. I remember feeling so confused. I loved my children so very much, they were all that mattered, although my behavior didn't reflect this love. I came to feel I was insane, immoral and a terrible mother.

I remarried another abusive man who was addicted. By now my disease had progressed and I was a daily heroin IV addict. I got on methodone maintenance to attempt to control that addiction. But then I simply became addicted to methadone, and I lost all motivation.

Again trying to "fix" my life I had two more pregnancies. "If

I have a baby, it will force me to pull my life together," I would tell myself. My only goal was to be a good mother to my children.

I would wake up sick every morning and try not to give in to the pain and cravings for drugs, only to break my promise daily. Neither of those children survived--one was born prematurely, the other was a victim of SIDS, I believe both deaths were secondary to my addiction.

I share this pain and tragedy openly today not only to the committee, but I lecture in the community, schools, churches, etc., as I believe if someone had intervened with love and empathy, and I had been offered appropriate treatment early, these tragedies would not have occurred.

I finally, after 16 years of addiction, many suicide attempts, and losing custody of my kids (temporarily to my parents), did go to Mountain Manor Treatment Center, a 30-day program. I did not go for me, I went for my children. I wanted to be able to take care of them. I walked in that place believing that I was a bad person, I was treated with love and respect, and they educated me about my disease. That was my beginning.

After treatment there, I was still physically addicted (i.e., drug craving, mood swings, inability to sleep) and had no where to go. I had no job skills, a 10th grade education, was on welfare, and knew I was doomed to fail. I volunteered for the only long term program available to Montgomery County residents with no insurance, Second Genesis.

That program had a punitive approach to addiction that was really designed to fit the needs of the judicial system. I wasn't allowed to call, write or see my children very often (we had two visits in 10 months), but I knew if I left there that I would use drugs again. My only goal was to be with my children.

Today I am Regional Director of Community Outreach and Education for Mountain Manor. I also am Executive Director over Social Model Detox Programs, and Maplewood Treatment Center for Montgomery County. I have been sober and drug free for 6 years, and I work with alot of addicted women. I have helped design our womens and childrens program, where children can go into treatment with their mother. I am also happy to report that one of my responsibilities on the Montgomery County Advisory Board was to re-design the long term facility in Montgomery County (which ironically enough was that punitive program that I described above) to reflect the disease model and to better meet women's needs.

I am certainly in total support of early intervention with addicted mothers; these women need treatment. These women are sick, they are victims of their environment, they are not criminals!

My ultimate dream for this severe problem would be to see the health and welfare systems do more training for early intervention, then use that knowlege to get these women into treatment.

Today, my oldest, Danny, is a freshman at the University of West Virginia; Carly is at home; and Erin is in 7th grade at Martin Luther King Junior High and she is on the honor roll. She asked me to submit for her today her own statement for the record in hopes that she could help people like us get what they need to stay healthy.

31-228 0 - 90 - 2

My children were the only motivating factor in my wanting recovery. I wouldn't be here if I had lost them, I know that. They taught me how to love myself. Through their unconditional love and innocence, I found strength. I love my children, I am a tremendous mother, I am grateful to God each and every day for my recovery, for my wonderful children, and today to the Select Committee for listening to my story. Thank you.

Prepared Statement of Erin 'X'

I remember moving a lot, never in one place long enough to keep a friend. Going to so many schools and then coming home to find my mom asleep. Sometimes she was asleep for an hour, and other times she didn't wake up until the next morning at 10:00 or 11:00.

I was always either late to school or I just didn't go. Now I am so surprised I didn't have to stay back. Sometimes I didn't take baths for days and when I went to school my hair was always a mess.

When I was 5 or so my brother and sister decided to move in with my grandmother. I stayed with my mom and I always stuck up for her. When my younger sister died is when I moved in with my grandmother and when my mom went to treatment.

I was sad always. I was only in second grade and I already needed tutoring. I didn't understand why my mom was away. I just thought it was really unfair and was always depressed. Everyone acting like she was such a bad person and I started to believe it.

When my mom came home she also moved in with my grandmother. I had started in a new school but it was different from the rest, it was clean and bright and much smaller. I didn't have any friends then. After my mom was back, she was a new person. She smiled more. She went to meetings a lot.

Then in 3rd grade I started doing good in school and making friends. I had never been this happy. I remember once when mom was using we went to a dance studio. I couldn't believe kids actually got to go to a dance studio. My mom said maybe one day. Well, after my mom's recovery I took dance lessons in that very same studio.

Now I know my mom isn't bad, she just had a disease. I also know it is hereditary and I could easily have the same disease. I wanted to come here today so I could help people like us get what they need to stay healthy.

Chairman MILLER. Thank you, Kathleen, very much for your testimony. Erin, we look forward to your written testimony. It's very nice of you to help the committee with your written statement and we'll make sure that all the Members read it. Thank you very much.

Dr. Tuckson.

Dr. TUCKSON. Thank you very much, Mr. Miller.

Chairman MILLER. Let me make a statement, if I might. I think Dr. Tuckson has a time problem. So when he's done with his testimony if Members have questions that are directly related to this testimony, we may just go ahead and let you ask those questions so that he can leave and make his other appointment.

STATEMENT OF REED V. TUCKSON, M.D., SENIOR VICE PRESIDENT FOR PROGRAMS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WHITE PLAINS, NY

Dr. TUCKSON. Thank you, and I appreciate that indulgence. The work of this committee is so very important to me personally and to the March of Dimes. I'll submit my written testimony for the record.

I'm going to try to respond to some of the things that were raised in what I think was the most compelling statement I've heard in a long time from the first witness.

We at the March of Dimes believe fundamentally that we have to care about people. We have to care about all of the women who are pregnant and who are suffering from the terrible consequence of drug abuse. We should remember that they are American women. They are our women and they deserve our concern.

As we debate public policy on these issues, I think that what is so very important, and I commend you for your foresight in bringing her first, is to realize that these are people with faces. I served as the health commissioner for the District of Columbia for four years prior to becoming the senior vice president of the March of Dimes.

I've had the chance to take care of these women in clinics, in poor neighborhoods on Wednesday nights and the one thing that impressed me over and over again, is that these are human beings who are suffering with a disease. As I struggled with my other responsibilities as the health commissioner for developing public policy, it becomes very important to keep that principle in mind.

The nature of the drugs that women of childbearing age are abusing, and we think that there may be as many as five million women, of childbearing age who are abusing drugs across this country, is that they are powerful drugs, and they're extraordinarily addictive drugs.

Unfortunately, they work very well. They work at a very fundamental level of our brain biochemistry and our anatomy. We don't know all that we need to know about why some people have been able to exert the "will power" to overcome and some haven't.

Is one person a "good" person and another a "bad" person because they couldn't overcome the addiction? No, we're just different people. These drugs work differently. Most people who are abusing drugs do so in combinations. One of the things we need to

realize is that these are women who, as we have just heard, do valium, do crack, do marijuana, and do a lot of other drugs all together. The pattern is usually not just one drug of abuse.

We also do not know the magnitude of the problem. We really need much more work on the studies. We estimate numbers like 375,000 children are exposed to drugs in utero each year, 100,000 children are exposed to crack each year. Is the number really 100,000? We don't know for sure. NIDA is doing the necessasry work now. And two years from now we'll know better what the numbers are. It would be ridiculous for any of us to think that the problem is not extraordinary, that it is not major, or that it is not growing.

We can debate whether it's 100,000 or 50,000. If it's 20,000, it's too darned many and the problems are just too great.

When we look at our responses to this problem, it is clear that we do not have enough prenatal care, period. Whether there was a drug abuse problem or not, it is incredible that still, after all these years, after all this technology, after all the spin-offs, we do not have enough treatment programs. We don't have enough drug treatment programs by several orders of magnitude.

What is even more frustrating is there is no relationship between the drug programs and the prenatal care programs. If we're going to treat women who are addicted and pregnant, we have to treat them in the context of the whole person. We have to care about the baby and the mother.

I don't understand how we ever get into discussions about separating the baby out from the mother. It's all connected, the mother's prenatal care is connected to the drug abuse care, the child is connected in utero to the mother. It's all one thing that needs to be coordinated and unified. Why we cannot devise a health care system that puts incentives for all of that to occur, I don't understand.

We just haven't put enough attention to it, it's not just money, it's also will. We have to case manage. We don't have the case managers to do this work. The social service systems are already overwhelmed and overloaded.

I would also say to you, Mr. Miller, one thing that I have come to learn, the answer is not the criminal justice system. You do not solve this problem by arresting women. You do not solve this problem by arresting children. It doesn't work that way.

If you put a barrier to access to people to come into the health care arena, people will not come to see you. If you say that you will go to jail or you will lose your child automatically by presenting for care, who in their right mind would come forward and participate willingly with the health care system.

Very quickly and to summarize, we have some things to learn. We have to learn more about what works. We have many more studies that need to be done. Do you know we only spend now $30 million in the Office of Substance Abuse Prevention to study this problem, to educate about this problem and for treatment programs.

All we have is 100 demonstration grants. Next year, with the funding that they have, all they will add is only 15 more. We don't know what the definition of success is, we don't know what works

and why it works. We don't know whether you should put women in programs that are residential and for how long versus outpatient care and which is more cost effective.

We don't know whether you should or shouldn't separate the child from the mother when they are in these kinds of programs if there's any reason to do it, scientifically or clinically.

We don't have any idea of what kinds of drugs really are going to be effective in the long run for managing things like cocaine or ice or, for the new threat of smokable heroin.

My five minutes is up. The thing that I would emphasize is that in the next few weeks, we'll be testifying for the March of Dimes in front of the Appropriations Committee. We're going to ask for $57 million for model prevention, education and treatment, well beyond the $30 million now allocated. We're going to ask for another $15 million to implement the Abandoned Infants Assistance Act because of all the children that are going to need foster care, and those sorts of things.

More than just asking for money, we're going to ask for compassion, for love, for care, for volunteers, for human beings to reach out to other human beings in this country. We're going to have to work continually with the executive branch as we look at ways that we can, at the state and federal and local level, to reorganize the pattern of care for how we provide services.

Thank you very much for being able to testify.

[Prepared statement of Reed V. Tuckson M.D., follows:]

PREPARED STATEMENT OF REED V. TUCKSON, M.D., SENIOR VICE PRESIDENT FOR PROGRAMS, MARCH OF DIMES BIRTH DEFECTS FOUNDATION, WHITE PLAINS, NY

Good morning, Mr. Chairman and members of the committee. I am Dr. Reed Tuckson, former Commissioner of Public Health for the District of Columbia, and now senior vice president for programs for the March of Dimes Birth Defects Foundation. I appreciate this opportunity to talk with you about the growing crisis of substance abuse during pregnancy.

This is an issue that Congress must care about, and I commend this committee for its concern. This is an issue that the nation must care about. Abuse of both legal and illegal drugs during pregnancy has an obvious, significant and devastating impact on America's mothers and babies. And for a variety of complicated social, environmental, biochemical, and psychological reasons, the problem is escalating rapidly.

Common sense, medical research, and clinical experience tell us that drugs are damaging to the human body. They also tell us that taking drugs during pregnancy has a devastating effect on the developing fetus. We know, for example, that cocaine use during pregnancy is associated with increased risk of spontaneous abortion, abruptio placentae, premature labor and stillbirth. We know that cocaine exposure is associated with malformation of fetal organs, especially the heart.

There is evidence that use of cocaine during pregnancy is associated with higher rates of Sudden Infant Death Syndrome. And

there is some evidence that cocaine exposure may lead to problems with emotional and educational development later in life. More study is needed to fully understand the long-term effects of prenatal cocaine exposure.

Drug abuse during pregnancy is also a driving force behind the increase in congenital AIDS -- AIDS that is passed from the mother to the fetus during pregnancy. Crack is so addictive that people will do anything to get it -- including trading their bodies. Sex-for-drugs transactions in the crack houses are spreading the HIV virus to more and more women of childbearing age. Their babies are being born with AIDS and dying within the first few years of life.

Drug-related sexual activity also is fueling the rise of other sexually transmitted diseases. Despite all the fear and publicity around AIDS, sexually transmitted diseases are a growing threat to the health of mothers and babies. The risk of other types of infection also is increased by frequent sexual contact, and we know that infections have been linked to premature birth.

Illegal drugs are not our only problem, however. Drinking alcohol during pregnancy can lead to fetal alcohol syndrome, a pattern of physical and mental birth defects that includes prenatal and postnatal growth deficiency, facial abnormalities, and a variety of malformations of major organ systems. Approximately 5,000

babies are born each year with fetal alcohol syndrome. And we estimate that about 50,000 are born with the less severe symptoms of alcohol damage known as fetal alcohol effects.

Similarly, smoking cigarettes during pregnancy is clearly associated with an increase in stillbirth, miscarriage, prematurity, low birthweight and neonatal mortality. Nicotine in tobacco smoke causes blood vessels to constrict, reducing the flow of blood to the womb and depriving the fetus of vital nutrients and oxygen. The fetus is also exposed to carbon monoxide, a toxic gas that has been shown to cause impairment of learning and memory in animal studies.

A study published in the Journal of the American Medical Association found that one out of five women smokes cigarettes throughout pregnancy, or about 750,000 women each year. The National Commission to Prevent Infant Mortality has estimated that smoking is responsible for about 25 percent of all low birthweight and about 4,000 infant deaths each year.

How widespread is the is the use of illicit drugs during pregnancy? The truth is, we don't know for sure. Not enough studies have been done, and the anecdotal evidence tells us that the epidemiology is changing rapidly for the worse. We do have some estimates, however.

Dr. Ira Chasnoff of the National Association for Perinatal Addiction Research and Education surveyed 36 hospitals in 1988 and found an average of 11 percent of women used heroin, methadone, cocaine, amphetamines, PCP or marijuana during pregnancy. Applying this percentage nationally, he estimated that as many as 375,000 infants may be exposed to drugs in the womb each year.

The study found that high rates of maternal substance abuse were not confined to large urban areas nor to hospitals with high rates of low income or public aid patients. And a follow-up study by Chasnoff in Pinellas County, Florida, supported the conclusion that substance abuse during pregnancy cuts across all socioeconomic lines -- affecting black women and white women, and private patients and clinic patients, in roughly the same proportions. The only major difference was that providers were far more likely to report a black woman to child abuse authorities.

The President's National Drug Control Strategy report puts the number of cocaine-exposed babies at 100,000 per year. More conservative estimates suggest 30,000 to 50,000. Whatever the exact number, it is clear that abuse of crack during pregnancy is significant and increasing. Anecdotal evidence gathered by this committee in a survey of 18 hospitals suggests there was a tremendous increase in maternal substance abuse between 1985 and 1988, and a major shift to crack cocaine as the drug of choice for women.

I am certainly aware from my experience as commissioner of public health in this city of the increasingly devastating impact of crack on mothers and babies. In the early years, we made slow but steady progress against infant mortality through initiatives that reduced the barriers to prenatal care. But in one year, those gains were entirely wiped out by crack cocaine.

Now in this city, we find 20 to 30 women each month who are so compromised by drugs that they must be picked up by the emergency medical service and brought to the hospital. On any given day, we find that as many of 75 percent of the babies in D.C. General Hospital are there because their mothers used drugs during pregnancy. And my colleagues all across the nation report similar experiences.

How are we going to respond? Certainly we need more information on the scope of the problem, and I am pleased that the National Institute on Drug Abuse has initiated a new prevalence study of illegal drug usage. Certainly we need enhanced understanding of the biochemical impact of cocaine on mothers and babies, and I would hope the federal government will join with the March of Dimes in supporting research in this area.

But what we need most of all is treatment. Yes -- individual responsibility is important. Yes -- parents, schools and

communities need to develop young people who can make the right decisions. But first and foremost, we must recognize drug addiction as a disease.

And we must recognize that people who have a disease need care. When it comes to the legal drugs, there are some programs that work. The effectiveness of 12-step alcohol cessation programs and smoking cessation programs are well known. We need to bring these programs into the prenatal care clinics and make them reimbursable under Medicaid and private insurer plans. We need comprehensive prenatal care that treats the whole person, not just the pregnancy.

When it comes to illegal drugs, we need to start by recognizing that people are not going to get care at the price of their freedom. Legal action against pregnant women who use drugs will not lock them into the jails -- it will lock them out of the health care system. It will breed distrust between physician and patient. Instead of coming into the system for care and a loving embrace, people will stay underground, spreading disease and living lives of quiet desperation.

Second, we need to decide how successful treatment is defined and how high a success rate we require. If we define success as making an addict 100 percent drug-free forever, then we have very few success stories. If we define it as making a chronic user into an occasional user, with longer durations between usage, then we have

many successful programs right now. Similarly, if we define success as helping every woman who enters a program, then we have few successful programs. But if we consider a program successful that retains and treats 20 to 30 percent of the women who walk in the door, then we have many good programs.

Third, we must increase our treatment capacity. Too many treatment programs refuse to take pregnant women. Too many have no treatment program for crack addiction. Too many programs refuse to take women on Medicaid. Pregnant women are waiting in line to get treatment. We need more clinics. We need more treatment slots.

Fourth, we need to increase the quality of treatment. Health care professionals need to be better trained to recognize and treat pregnant substance abusers. Drug treatment needs to be coordinated with prenatal and obstetrical care services. We need more case management workers to ensure delivery of comprehensive, appropriate care.

Fifth, we need to identify the most effective approaches to treatment and replicate them around the country. Next week, the March of Dimes will testify before the Appropriations Committee and we will ask Congress for $57 million for model prevention, education and treatment projects for substance abusing women, conducted through the Office of Substance Abuse Prevention. We will also request $15 million to implement the Abandoned Infants

Assistance Act, which will provide foster care for drug-addicted and HIV-positive infants who are abandoned in hospitals.

Finally, we need to develop the national will to finance high-quality treatment that is integrated with prenatal care. We need to clearly define the maternal substance abuse treatment and services that should receive priority financing and what they will cost. Once this is done, these costs can be balanced against the societal costs of failing to provide treatment, including the costs of ICNs, boarder babies, foster care, and special education for developmentally disadvantaged children.

I believe these numbers will clearly demonstrate that it makes moral, medical and financial good sense to pay for drug treatment instead of paying for the consequences. Thank you.

Chairman MILLER. Thank you.

Do any members have any specific questions they'd like to ask of Dr. Tuckson? Mr. Bliley.

Mr. BLILEY. Mr. Chairman, I just have a couple. I appreciate Dr. Tuckson taking time to be with us.

From what you say, since there's so much we don't know about this disease and what to do about it, don't you think it would be better for us to grant funds to states and local government and let them decide best how to proceed in their particular situation, rather than for us to try to direct it from Washington?

Dr. TUCKSON. That's an excellent question, and I appreciate it. I have had the responsibility for running programs for a city/state/county environment. Certainly I had some very clear ideas about how we should spend our money, and thought we were very thoughtful and smart about some of that and, in fact, we were thoughtful and smart about some of it.

We made a decision, for example, and this is a horrible decision to make when you think about the consequences of it, that because of the lack of availability of drug treatment programs in our city, we had to make a prioritization. That's an immoral position to be in. We said that any pregnant woman that wanted care would get it the same day she wanted that care, even if it meant, and it did mean, that some men didn't get care.

So we made a choice and we prioritized. We went and sent letters to every community leader and civic leader and church leader that we could find and said if you know of a pregnant substance abuser, you get that person to us at this phone number, at this number, cut through all the bureaucracy, you get treated the same day.

The problem with that is, while that is wonderful stuff, we can do some things, I don't want to be overly pessimistic about the capacity to treat substance abuse now. There are success stories all around us every day, as we've just heard, but do we really have those clinical skills based upon the kind of research data that we really need so that we're really good at what we do.

Can we at the local level, when we create these programs, really go to the local legislature and say to them that this is the cost benefit equation for how we will spend our resources, that it's better to put a person in a residential program for a year and a half because it decreases the recidivism rate, as opposed to a year, but in making that choice I'm going to spend more money per client, I'm going to use up more of the treatment slots that are available there for effecting the waiting times and so forth? Can I really sit in front of my state legislature or my city legislature and say to them that I know the answers to those questions?

Can I really say to my clinicians in those clinics that I know exactly how to manage this disease? No, I can't do those things. Should the federal government be exercising that leadership role? Should it be devoting its resources at NIH, NIDA, OSAP and all those various places to answering those questions? Unquestionably. They have to be the ones to do it. No local municipality could possibly do that work.

They're doing that work now, they're doing it with commitment, they're doing it the best they can, but somewhere we have to pool

the money together, pool the intellectual talent of this country together to answer those questions.

Mr. BLILEY. I don't think that we were disagreeing. What I meant was, and what I gather from what you say is that, yes, we need to do a lot more research, but we're not in a position at the federal government to set up a program nationwide to decide exactly what ought to be done in Washington, or Richmond or San Francisco or wherever.

Dr. TUCKSON. I appreciate that and I appreciate the way in which you're asking. This is not a debate and I don't think that we disagree. Not to take up more than my fair share of the time, the point that I would get to is local municipalities must, of course, tailor their problems and their responses to the local environments that they see.

My concern simply is, is that there is a data base which would serve well that decision making and that public policy debate at the local and state level that is not now available. I just think that the leadership for that supply of information, whether it be clinical research or managerial and administrative research, has to come from the federal level. I think that I do understand your question more, and I don't think that we are in opposition.

Mr. HASTERT. I think you're probably right. Research and developmental research is the job of the federal government. It's estimated between 1989 and 1991, for instance, OSAP demonstrations are going to be increased 732.7 percent, which is quite an increase and commitment. It depends on where you're starting and where you're stopping.

I also agree the delivery of services needs to be tailored on the local level. If you're talking about Montgomery County, Germantown or a little rural town in Illinois you're talking about very different needs in each area. We need research, but we need research that can apply to the problems confronting various areas of this country.

I see a substantial increase in dollars spent for research. Here everybody wants dollars, whether you're looking at the back board of this building or this room, or wherever, and you need to know what kind of bang for the buck you're getting for those dollars. I appreciate your testimony.

Chairman MILLER. Anyone else?

Mr. MACHTLEY. I just have one question. You've obviously been on the front line dealing with people, real people, we've seen a lot of academic people who are suggesting that we should legalize drugs, make a trade, free drugs for treatment.

Do you have an opinion, be it your personal opinion, or something that you could represent from the agency you're now working for? Should we legalize drugs, should we be radical in our approach to drug treatment, particularly as it relates to women?

Dr. TUCKSON. Sir, I'll speak more from my experience as the health commissioner for this city that has suffered the scourges of it. I am not an advocate of legalizing these drugs. I am certainly extremely concerned as I realize the addictive potential of these drugs.

I have seen and counseled and held and cried with too many women, too many men, who have exposed themselves, for whatever

reasons, to these drugs and have had to struggle time after time to try to get off of these drugs. I don't think that these are drugs that can be treated casually or lightly.

I know that there is an inadequate system currently available to manage the people that are already addicted. I would hate to see money going towards creating a system where we now give out drugs. We don't put enough money into treatment of drugs, now we're going to create another infrastructure to give it out, I'm very concerned.

Too many people like this lovely person who testified have tried, failed, tried, failed, but then eventually succeeded. I would hate for them to have to even begin that cycle. As the March of Dimes senior vice president, I also have to be very concerned about the developing fetus. We have to care about that baby.

These drugs cannot in any way be neutral to the development of these children. We simply could not tolerate emotionally, ethically or responsibly the introduction of these drugs into women of childbearing age, already we know there are far too many that are abusing them.

Mr. MACHTLEY. Thank you very much.

Chairman MILLER. Dr. Tuckson, I might ask you, you mentioned and it's obvious, I think, part of what we're searching for in this committee, and that was you mentioned the failure to link up drug treatment, education and prenatal care in getting to women early on in a pregnancy, prior to the next pregnancy. How do we do that?

When we look at treatment programs for pregnant women, it's roughly a million dollars a state. I mean, it's a very small amount of money given the universe that we're discussing here. How do we make this linkage? Do you have a position on that?

Dr. TUCKSON. As you appreciate well, you've studied these issues as well as anyone, it's not easy to do. It first of all requires a commitment and a desire to do it. We have to decide that we will reorganize the way we provide our services, whether it be services provided by the state or whether they be in the private sector.

Secondly, we're going to have to train the various ends of the dyad to not only care, but to know something about it. The drug people have to understand something about pregnancy and the pregnancy people have to understand something about drugs.

The third thing we have to do is create that interface opportunity. What would be the most ideal is we would create clinic environments where all of this can occur at one place, one-stop shopping center, not only for the Medicaid enrollment and the financing issues, but also for the drug treatment and the prenatal care at the same place.

Short of that, we're going to need unquestionably the case managers, those kinds of human beings, resource persons, who are able to look at the multiple development and multiple issues involved and cause all of the necessary things to occur so that the person who needs services such as child care for the other young children as we've heard, can have someone to help with that as they go to the drug clinic or the prenatal care.

So we're going to need that kind of a human being, that kind of professional that can bring it all together. Then I think we're going

to have to look for financial incentives, as we pay for care in the private sector, and give the incentives.

We know that the health care system responds to financial incentives. So I think we have to find those kinds of creative ways.

That's the way I would look, at least, to approach.

Chairman MILLER. Thank you for your time. We'll let you go.

Dr. TUCKSON. By the way, I appreciate the indulgence, and I have also appreciated the indulgence of my panelists.

Chairman MILLER. I have a number of questions that I would like to submit to you, if you might answer them, for the committee, and other members may also do that.

Dr. TUCKSON. Yes, sir.

Chairman MILLER. Mr. Besharov.

STATEMENT OF DOUGLAS J. BESHAROV, RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. BESHAROV. Mr. Chairman, Members of the Committee, it's a pleasure to be here. I'll submit my formal comments for the record.

Substance abuse, and especially crack cocaine, is the single most serious child welfare problem facing the nation today. Upwards of 50,000 children are born each year having been exposed to cocaine, many hundreds of thousands more live in the care of substance abusers. Their needs and the needs of their children are very great.

I was in Contra Costa County three weeks ago, Mr. Chairman, and had the opportunity, actually the very great pleasure, to do some training for almost all the child welfare workers in the county. I asked for a show of hands. I asked, "How many workers in this room," I said, "have at least 50 percent of their caseload involved in drugs?" I said, "Not marijuana, not alcohol, illegal drugs beyond marijuana?"

About 90 percent of the hands went up. Drug use by parents is a scourge. This is a problem that goes beyond many of the issues that we've talked about in the past before this committee, because this has taken on a life of its own. It has recharacterized the problems of poverty and child welfare in this country.

In less than two and a half years we've had a 30 percent increase in the number of children placed in foster care, and those numbers are increasing rapidly. We're seeing a major shift in who goes into foster care. The racial dimension of this problem is very serious, whether it's because of reporting, or because of the demographics of usage.

In California, for the first time in history there are more black children in foster care than white, and that's in a state with a black population of only 12 percent. The rate of placement is three times as great for black children, that's black poor children.

Right now one in three foster children in this country comes from either California or New York, and this is a sign that the problem is related to heavy drug use in our major cities and urban areas.

I think as we talk about this problem it's very important to make a distinction between the issues that are being raised. Some have to do with drug treatment, but I want to talk about the child welfare dimension.

I'm not one of those people who thinks that the exposure of a child to drugs ipso facto creates a child welfare problem. The question is the ability of the parents, usually unfortunately, only the mother, the ability of the mother to care for those children. Unfortunately, from everything we know compulsive drug users, and I use that word carefully, compulsive drug users, are too busy doing other things, and their judgment is too impaired, to care for their children properly. This is what's creating this very large child welfare problem.

When child welfare agencies turn to drug treatment agencies for help, they get very little. It's not so much because they're in those slots, in fact, although there can be a debate about exactly how much, in my own home state of New York, we have relatively easy access to drug treatment. Our problem is that it doesn't work.

Our problem is that there are high relapse rates. Our problem is that unlike heroin addiction, there is blocker that helps treatment efforts. So it's typical for treatment professionals to talk about relapse after three months or six months, and talk about treatment that can go on for years.

The problem with that approach to treatment, and that may be the best we can do, is that in the meantime there are children at home, sometimes, not always; but sometimes being brutally abused or neglected. It's in those situations that child protective agencies become involved. They don't have the luxury of saying we'll do some research so that in two years or three years we'll get some answers.

Each day child protective workers go out, look at a family and decide what to do in the absence of treatment, whether there is no money or no treatment technology. They're having to decide whether to remove children from their homes.

The challenge and the problem is what to do once these children are removed. I would say to you, as I describe in my written testimony, that federal legislation sends the wrong signal about the need to place some children, and we're undoing it at the state level, but it would be very helpful if we could get a better signal from the federal level as well.

For ten years child welfare professionals have worked very hard on the family preservation movement. We believe in trying to keep families together. But existing federal legislation seems to put all the marbles on that one side. It talks about the requirement that there be reasonable efforts before removing children from their parents, and we all, I think, agree to that.

The point is that for some very heavy, compulsive drug users, where the abuse to the child is serious, reasonable efforts mean removing the child right away. It would be very helpful if federal legislation authorized, not required, just authorized states to take that kind of prompt action when necessary.

The second thing that I'd recommend, Mr. Chairman, is that we authorize a top to bottom overhaul of the way child welfare agencies do business. We're not going to have any magic panacea about how to treat abusing parents or drug using parents, but we do know enough now to give the states much greater leeway in how they deploy those services.

So I'm a real supporter for the bill that I believe is being worked up in the Ways and Means Committee. It would allow states to come to the Secretary of HHS and ask for a waiver of various federal requirements so that they can reorganize their child welfare services to better meet the needs of these families.

There's one last point that I'd like to add and then I'll stop, and that's in relation to your question to Dr. Tuckson about what to do in prenatal care and what to do when we have a young, pregnant woman or thereafter.

One of the things we can do is get it clear in our mind what our objective is. There have now been two major national studies about the degree to which child welfare agencies and public assistance agencies talk about family planning with their clients, and the answer is: just about not at all.

Many of the mothers who have babies a second and third time could use some advice about family planning. We ought to be very clear this is not a question about abortion, this is simply a question about making available information about how to avoid being pregnant. Whatever the debates are about the broader issues, when we are doing drug treatment counseling and prenatal care counseling, we ought to be very clear that we want to help these women avoid having more children, if they want the help.

Thank you, Mr. Chairman.

[Prepared statement of Douglas J. Besharov follows:]

Prepared Statement of Douglas J. Besharov, Resident Scholar, American Enterprise Institute, Washington, DC

Mr. Chairman, members of the committee, thank you for inviting me to testify before you on this important and troubling subject.

I will focus my remarks on only one aspect of this multifaceted problem: the effects of parental use of crack and other drugs on state and local child welfare programs. After describing the scope of the problem, I will share with you the results of our national survey of state agencies which found that, in a twenty-four-month period, the number of children in foster care had increased by almost 18 percent, from an estimated 280,000 children in June 1987 to an estimated 330,000 in June of 1989. By June of 1990 the number of foster children is projected to increase to 360,000, for a total increase of 28.6%. I will then discuss how this unprecedented increase in foster care poses both moral and administrative challenges to child welfare agencies and to society as a whole. Finally, I will make five suggestions for your consideration.

The Scope of the Problem

Children are the most heartrending victims of the current drug epidemic. Each day, about 100 babies are born who have been exposed to crack and other drugs before birth. Tens of thousands of older children live with their drug-addicted parents in deplorable conditions. Drug Czar William Bennett called these children "the worst casualties" of the nation's drug problem.

The problem of finally-exposed babies, called "crack-babies," spread quickly—like the use of crack—from city to city and, more slowly, to smaller cities and suburbs. No one knows how many crack babies there are. The most widely cited estimate was made by Dr. Ira Chasnoff, director of the Perinatal Center for Chemical Dependence at Chicago's Northwestern Medical School. In 1988, he surveyed 40 hospitals, of which 36 responded. On average, the responding hospitals reported that 11 percent of pregnant women they saw in 1987 were substance abusers. (The high was 27 percent, and the low 0.4 percent.) Dr. Chasnoff took this 11 percent average and simply multiplied it against all live births in the country that year (3,809,394)[1] to arrive at the much quoted statement that: "as many as 375,000 infants may be affected each year."[2]

This estimate is much too high. The 36 hospitals in the study accounted for less than 5 percent of all live births in 1987 and, more importantly, they were hardly representative of the nation as a whole; roughly two-thirds were located in large cities. Also, in the study, "substance" was broadly defined as heroin, methadone, cocaine, amphetamines, PCP, and marijuana.

A better picture of the problem can be obtained by looking at the experience of a number of cities. Washington, D.C., is probably the area hardest hit by the crack epidemic, and yet, its approximately 1,500 drug-exposed babies in 1988[3] comprise only 7.5 percent of live births in the District and 15 percent of live births by District residents.[4] Similarly, in New York City, another concentrated area of heavy drug use, the number of drug-exposed babies just about doubled between 1986 and 1987, increased another 70 percent in 1988, and is projected to increase another 70 percent this year—to 6,876 drug related births a year.[5] But these 7,000 drug-related births represent only about 5 percent of all live births in the City.[6]

Thus, a national total of 1 or 2 percent of all live births, or forty to sixty thousand crack babies, seems a more realistic figure. These numbers are large enough to make crack babies a national concern. Even at its peak in the late 1980s and early 1970s, heroin withdrawal affected only one tenth as many newborns and it did much less damage to them.[7] Exaggerating the size of this terrible problem only makes it seem more unmanageable than it already is.

The problem of fetal exposure to cocaine and other drugs is so large that it raises overall infant mortality rates. In Los Angeles County, the number of drug-associated fetal deaths increased from 9 in 1985 to 56 in 1987.[8] Dr. Richard S. Guy, cochairman of the D.C. Mayor's Advisory Committee on Maternal and Infant Health, has said that D.C.'s infant mortality rate is "going to go up" because of the "tremendous increase in the

---

[1]U.S. National Center for Health Statistics, Advance Report of Final Natality Statistics, 1987, U.S. Department of Health and Human Services, Vol. 38, No. 3, Supplement, June 29, 1989, p. 1.

[2]Press Release, National Association for Perinatal Addiction Research and Education, August 28, 1988. Data from survey funded by Office of Substance Abuse Prevention and the March of Dimes Birth Defects Foundation.

[3]Young, Michal, M.D., D.C. General Hospital, Washington, D.C., telephone conversation, April 12, 1989.

[4]Telephone conversation with Stephanie Ventura, U.S. National Center for Health Statistics, August 14, 1989: 20,529 live births in the District, of which 10,208 were by District residents.

[5]New York City HRA Office of Management Analysis, November 17, 1988.

[6]The number of live births in New York City in 1987 was 122,800. Source: Stephanie Ventura, U.S. National Center for Health Statistics.

[7]See e.g., The Children of Addicts: Unimagined and Unpredicted, Study Report no. 3, Select Committee on Child Abuse (New York State), October 1972.

[8]Clement, Douglas. "Babies in Trouble," Minnesota Monthly (March 1989), pp. 47-51, p. 48.

number of mothers abusing drugs."[5]

Crack and Child Welfare

Although other drugs have plagued our society, most users have been men. Crack, a derivative of cocaine, has changed this pattern. For the first time, there are large numbers of female addicts, many of whom have children or are pregnant.

Crack is a different kind of drug, too: it is a mean drug that infuses some parents to incredible violence. In one widely reported case, a five-year-old girl was found dead in her parents' apartment with a broken neck, a broken arm, large circular welts on her buttocks, and cut-and bruised on her mouth. Her nine-year-old brother was found the next day huddled in a closet. Both his legs were fractured; he had eight other broken bones, and bruises covered his body.

Children who are not physically assaulted may be victims of their parent's neglect. "People who start using have got to find that money. Children aren't being fed," says Maurice Macey, western regional manager for Missouri's Division of Alcohol and Drug Abuse. "Mothers sell their food stamps. Young women sell their bodies, and that's done in front of the children. Even when heroin was at its worst, it wasn't like this--it wasn't openly done." In one case, a 10-month old died after being left overnight in an overheated room--the temperature reached 110 degrees--while his mother visited her boyfriend.

Almost twenty years ago, as the director of the New York State Assembly Select Committee on Child Abuse, I studied heroin withdrawal babies in New York City. Nothing I learned then prepared me for the devastating damage cocaine is now doing to American children.

Concerned about the increase in such cases, the American Enterprise Institute, the American Public Welfare Association, and Abt Associates obtained funds from the U.S. National Institute of Justice to conduct a nationwide survey of state child welfare agencies to gauge the impact of substance abuse on child protective and foster care programs.

Our survey of all 50 state child welfare agencies reveals an unprecedented surge in the number of children removed from their parents and placed in foster care. APWA estimates that, in June 1987, there were about 280,000 children in foster care; by June of 1990 the number is projected to increase to 360,000. That's a 29 percent increase in just 36 months--and the numbers are still rising. See Tables 2 and 3.

Between 1986 and 1989, an estimated 80,000 children were added to the foster care population. However, the increases have been quite uneven, as you can see from Table 1. The communities hardest hit by crack addiction have experienced startling increases. Two states (California and New York) were together responsible for 55 percent of the increase. California's foster care population rose 41 percent during this period, from 47,327 in 1986 to 66,763 in 1989. In New York there was an increase of 90 percent, from 27,504 children in 1986 to 52,189 in 1989. (The increase includes about 10,000 children placed with relatives.)

Today one out of three foster care children comes from either California or New York, although fewer than one out of five American children lives in these two states. In 1986, the ten states with the largest foster care populations accounted for 55 percent of the national foster care population. Now roughly two out of three foster care children in the country reside in these ten states: California, Florida, Georgia, Illinois, Massachusetts, Michigan, New Jersey, New York, Ohio, and Pennsylvania. Georgia's foster care population rose by 43 percent between 1986 and 1989. Illinois, Massachusetts, and New Jersey also experienced large increases in their foster care populations.

In states without a serious drug problem and in those that have not responded to the need, foster care statistics have remained flat. Washington, D.C., I am afraid, is in the second category. Part of the explanation is money. Foster care, especially for these children, who often need special treatment, is expensive, and the District of Columbia seems determined to save money by ignoring their plight. Earlier this year, nurses at D.C. Children's Hospital notified the District's child protective agency each of the two times that a one-year-old child was sent home after testing positive for PCP, and both times he was returned to the hospital with a higher level of drugs. Typically, the District's Child Protective Services agency will not become involved unless the mother abandons her newborn.

---

[5] Abramowitz, Michael, "Mothers' Drug Addictions Imperil Newborn's Lives," Washington Post, B1, col.5., February 22, 1989

Table 1

CHILDREN IN FOSTER CARE
1986-1989*

(Based on the last day of the reporting period)

STATE	FY 86	FY 87	FY 88	FY 89
Alabama		4,337	4,390	4,417
Alaska	1,232	—	—	
Arizona	2,434	2,641	3,008	
Arkansas		1,321	1,092	1,077
California	47,327	51,821	62,514	66,763
Colorado		3,100	2,941	2,881
Connecticut	3,530	3,370	3,631	
Delaware		783	696	698
Dist. Columbia	—	2,120	2,210	
Florida	6,802	7,017	7,725	7,544
Georgia	9,311	10,356	11,597	13,325
Guam		—	37	39
Hawaii	1,287	1,423	1,400	
Idaho	756	1,307	770	
Illinois	14,472	15,829	17,425	19,286
Indiana	4,730	5,207	6,045	
Iowa		3,579	3,856	4,012
Kansas	4,203	4,277	4,443	
Kentucky		2,863	3,235	3,232
Louisiana		6,717	6,717	6,097
Maine	1,855	1,855	1,815	
Maryland		5,198	5,470	5,868
Massachusetts	7,546	8,814	9,588	10,284
Michigan		8,566	9,791	11,302
Minnesota		5,616	5,924	5,900
Mississippi	2,219	2,587	2,702	
Missouri	6,354	6,515	6,902	
Montana	—	—	—	
Nebraska		2,438	2,432	2,296
Nevada	1,876	1,264	1,590	
New Hampshire	—	1,264	1,445	
New Jersey	6,597	8,681	8,542	8,798
New Mexico	2,062	2,088	2,195	
New York	27,504	29,197	45,746	52,189
North Carolina	6,254	6,124	6,126	
North Dakota	587	540	589	
Ohio	11,966	11,263	12,539	14,200
Oklahoma	2,075	2,048	2,217	
Oregon	3,250	3,623	3,885	
Pennsylvania	14,685	13,433	14,636	15,416
Puerto Rico	2,252	—	—	
Rhode Island	2,085	2,293	2,569	
South Carolina	3,692	3,563	3,583	
South Dakota	547	461	446	
Tennessee		4,409	4,590	5,077
Texas	4,727	4,769	5,449	
Utah		1,132	1,176	1,118
Vermont	1,025	987	1,025	
Virginia	5,902	5,898	6,011	
Virgin Islands	—	—	—	
Washington	5,789	5,632	5,725	
West Virginia	—	1,955	—	
Wisconsin		4,833	4,826	5,018
Wyoming		595	608	762
Totals:	27,180	287,973	325,885	307,815

*State foster care populations for fiscal years 1986, 1987, 1988, & 1989 based on VCIS data collected by the American Public Welfare Association.

Table 2

ESTIMATED YEARLY INCREASES
FY1986-1989

Year	Estimate	% Increase from FY 86
FY 86	280,000	-
FY 87	295,000	+ 4.6%
FY 88	330,000	+17.9%
FY 89	360,000	+28.6%

Table 3

ESTIMATED INCREASES IN SELECTED STATES
FY1986-1989

State	% Increase
California	41%
Florida	11%
Georgia	43%
Illinois	33%
Massachusetts	36%
New Jersey	33%
New York	90%
Ohio	19%
Pennsylvania	5%

Foster Care Limbo

There are many levels of drug use and, media coverage notwithstanding, some drug-using mothers can care for their children adequately, at times with social service support. In recent years, we have learned a great deal about working with abusive and neglectful parents; programs across the country are helping many thousands of parents, including those who use drugs, to take better care of their children.

Unfortunately, nationwide, there is a severe shortage of drug treatment programs, especially for women; most programs have long waiting lists, and many do not accept pregnant women or mothers. These conditions have led to calls for an expansion of treatment programs for drug-using mothers and women in general, which I certainly support. However, expanded treatment, no matter how richly funded, will not be the total solution to the problem. Even the best programs have only modest success treating hard-core addiction.

What we cannot do for crack addicts in general, we cannot do for addicts who happen to be mothers. Hard-core crack addicts are exceedingly difficult to reach. "To get off drugs one must be motivated by love or dedication to something greater than personal pleasure or pain," explains Edwin Delattre of Boston University. "But the circumstances of these young people--without education and opportunity--thwart the formation of such motivation and this, plus the intense pleasurability of cocaine, makes successful treatment almost impossible for many addicts."

Years of effort have yielded no widely applicable therapeutic program for treating heroin addicts. The only practical treatment for large numbers of these addicts is methadone maintenance. No similar "blocking" agent for cocaine has been found, although there have been some initially promising experiments with anti-depressants. Years of work, however, will be necessary to see whether these drugs, or some new approach, will work. "Crack is new enough that no one has yet figured out an effective treatment," according to Peter Reuter, a Rand Corporation expert on drugs.

Thus, for the foreseeable future, we must be prepared for the reality that agencies will have little or no success in treating heavily addicted parents. And we must likewise be prepared for the reality that the children of these parents--again, not all children of drug-using parents, but those of parents with serious problems--must be placed in foster care.

Despite the conventional wisdom about the foster-care crisis, the vast majority in the system receive good physical care, often substantially better care than their parents can provide. The problem lies in foster care's emotional impact. Children who stay in foster care for more than a short time, especially if they are older, tend to be shifted through an unsettling series of ill-suited foster homes, denying them the consistent support and nurturing that they desperately need. These problems are magnified for the children of addicts.

Because their home conditions are usually so bad and treatment has only limited effect on their parents, once placed in foster care, these children of crack tend to stay there. In New York City, 60 percent of the babies discharged from hospitals to foster care--mostly crack babies--were still in foster homes three years later. Of those in foster care, more than half (56 percent) had been in two or more foster homes; 20 percent had been in three or more homes. One child had been in eight homes.

Foster care was designed to be a temporary remedy used only until parents are able to care properly for their children. Today, foster-care procedures are still designed to reunite families as soon as possible. This important goal can be carried to extremes, however; in one case, an infant who was discharged from a six-month foster care placement and returned to her mother and grandmother was found four months later to have serious burns on her back, possibly made by a clothes iron. The child was immediately returned to foster care. Subsequently, the mother admitted using crack to her social worker, and six months later, despite being enrolled in a drug treatment program, she gave birth to a baby with symptoms of cocaine addiction. Yet the agency's goal was still to return the girl, by then almost three years old, along with her newborn sibling, to their mother.

Many judges and caseworkers would place more children of addicts in foster care, but they believe that the emotional limbo of foster care can be as harmful to these children as living at home with their drug-using parents. They reason that many children, after years of unsettling foster care, will end up back at home with those same parents. In effect, these professionals are choosing between two harmful situations and deciding that many children would be better off in the care of addicts. But there are other options.

The Moral Challenge: Adoption

Increased adoptions by loving adults is one route out of foster care limbo. Unfortunately, current legal rules and agency policies make it exceedingly difficult and time-consuming to terminate parental rights. As a result, fewer than 10 percent of the children in foster care are put up for adoption.

Even in the most alarming cases, few children are quickly made available for adoption. One crack baby was placed in foster care after his father killed the boy's baby sister. The mother, who was frequently beaten by her husband, was in touch with the foster care agency only sporadically. Three years later when she gave birth to yet another cocaine-exposed child, the first youngster still lived in a temporary foster home.

The growing foster care population of crack children is forcing a fundamental re-examination of state adoption laws. Most people seem to agree that adoption laws need to be changed to reflect the realities of drug addiction, to make adoption a real option for children whose drug-addicted parents, usually mothers, cannot care

for them and who show little prospect for improvement. The question for legislators is: Where to draw the line?

Making it too easy to terminate parental rights would be as harmful as current policy and would face legitimate opposition. What if, for example, a drug-addicted parent is willing to accept help but the help available is ineffective? Or worse, what if there simply is no treatment at all?

Many of these mothers are barely more than children themselves. Usually poor and seeing little prospect for the future, they are, in a sense, themselves victims of extremely difficult circumstances. It is disconcerting to take such harsh action against these young mothers who are trying--albeit unsuccessfully--to improve their troubled lives.

Moreover, even though there are many more potential adoptive parents than casual observers believe (there are waiting lists to adopt spina bifida and Down's syndrome babies, for example), some foster children--older or handicapped--are not readily adopted. For these children, terminating parental rights is not freeing them for adoption but, instead, casting the last tie to their biological families. This is particularly troubling because, in time, some parents will conquer their drug problems.

The issue of race also heightens our unease. Drugs, and especially crack, take their greatest toll on those least able to bear the burden--members of disadvantaged minorities. In California, for example, for the first time in that state's history, the absolute number of black children in foster care exceeds the number of whites, even though less than 10 percent of the state's children are black. A tough policy for taking children away from parents that falls most heavily on minority communities should make everyone think twice.

These considerations are largely mitigated when a parent is offered a reasonable program of treatment and flatly refuses to accept help. Thus, it seems appropriate to amend state laws to encourage adoption in such cases--especially for young children. Whether more ambiguous situations will also be made grounds for terminating rights will be determined after a spirited debate about the rights of children versus the rights of parents. As my previous remarks suggest, I believe that a moderate loosening of adoption laws is long overdue, but, as I have also tried to suggest, there are important competing values at stake.

In any event, even under the most liberal adoption law conceivable, many children of addicts will continue to live in foster care for long periods, so we should also be working to give them as normal a life as possible.

The Administrative Challenge: Better Foster Care

Foster care must be restructured so that it can provide the kind of nurturing care children need. This means stable care over the long term.

The first priority must be to have the highest quality foster parents. Most agencies, however, are having difficulty recruiting high-quality foster parents and have been forced to modify their recruitment criteria. Many, for example, now allow single women who work full-time to be foster parents--even though they have to hire others (usually without agency supervision) to care for infants and toddlers.

Although the worsening physical and behavioral problems of foster children partly explain why it is so hard to attract new foster parents, simple economics is a more serious obstacle, and one more amenable to solution. In many places, payments to foster parents have not kept pace with the inflation of the last decade. Even when they have, agencies must compete against the marketplace for the mothers who were once their prime source of foster parents and who are now increasingly in the paid labor force. If we want to attract better foster parents, we will have to pay them more than $4,000 per child per year, the approximate national average.

Giving long-term foster children a sense of permanency must be the second priority. One idea being considered by many states is called "permanent guardianship." In this arrangement, the child is placed with an individual willing to accept permanent responsibility for the child's upbringing. This new guardian has all the legal rights of a parent (the agency is no longer involved) but the parents are able to maintain contact with the child. This has proven to be especially helpful in cases where the child is older and the placement is with a relative or a long-term foster parent who has developed a relationship with the parents.

When on-going support from the agency is needed, perhaps because the child has severe handicaps, some states allow the child to be placed in a status called "permanent foster care." This gives the child a constant and secure home but allows the agency to stay involved.

Placing children with relatives is another solution to the shortage of good foster parents being tried. In New York City, almost one in three foster children are in the formal care of relatives, who are receiving full foster-care payments.

The advantage of all these new arrangements is that they avoid a complete break in family ties. But that is also their most serious disadvantage. Relatives sometimes return children to their parents without telling the agency, either out of fear or solicitude. Non-relative foster parents sometimes refuse such arrangements because they do not like the idea of having a drug addict involved in their lives. Clearly, more study and experimentation will be needed.

Some commentators have called for a return of the orphanage. For older children, some sort of small congregate care arrangement, like a group home, makes a great deal of sense. For infants and younger children, living in a home and family setting is best, and it ought to be our goal.

Concrete Solutions

Up to now, I have tried to describe the underlying ethical and policy decisions that confront us. Now let me be more specific. Immediate action is needed on five fronts:

1. There needs to be an extensive, nationwide public awareness campaign that teaches that drugs and pregnancy do not mix. Some young mothers still do not believe that crack is bad for their babies. They are often addicts giving birth to healthy babies and they convince themselves that they will, too. It's a little like what some smokers say to defend their habit: "You should see my Uncle Harry. He's 70 years old and has smoked three packs a day for 50 years." Well, the law of averages hasn't caught up with Harry, but others are not so lucky.

Hard as it is to imagine, after all we know about the harmful effects of cocaine, there is still no concerted effort to use government public service announcements to tell young women of the dangers of using drugs while pregnant. As middle-class mothers then even cut back because of its caffeine, continued silence is inexcusable. The Department of Health and Human Services, perhaps under the personal leadership of Secretary Sullivan, should use every media avenue to get the word out. Whether it is in sex and health education classes or in public affairs TV spots, euphemisms like "Beautiful Babies: Right From the Start" are no longer enough for this crisis. The message needs to be blunt: "Using drugs while pregnant is dangerous--for mothers and babies."

2. Hospitals should be given the legal power to care for drug babies until they are medically and mentally ready for discharge. After a drug-exposed child is born, hospital and child protective agency decision-making should focus on (1) the mother's ability to care for the child and (2) past instances of physical violence--especially by men in the household. They should also make a realistic assessment of the mother's ability to meet the special needs of a fragile, drug-weakened newborn. (Some crack babies die because their mothers cannot provide them with the intensive care they need just to survive, care that many non-addicted mothers would have difficulty providing.) Because of the close coordination and immediate communication often needed in these cases, some child protective agencies are posting workers in hospitals that see large numbers of drug mothers.

About half the states have laws that allow hospitals to hold endangered children against parental wishes. These laws protect children when there is no time to apply for a court order or obtain police assistance. All states should have them, and the federal government's National Center on Child Abuse should provide technical assistance on the subject.

3. Financial resources to care for drug babies in hospitals should be better directed to them. More medical knowledge about how to treat these children is also needed. This includes research on the treatment of immediate problems and remediation of long-term deficits, as well as new hospital protocols that address both the medical and social conditions of drug babies to improve diagnosis and care planning.

Recent amendments to the federal Medicaid program guarantee that most hospitals will be reimbursed for the added and sometimes extraordinary costs of caring for these children. But because of the way DRG-type reimbursement schemes operate, there is no legal need to apply those funds to the children's actual care. And, in fact, many hospital systems use these funds to cross-subsidize other programs. Many of these other programs involve equally pressing human needs, but Congress intended these funds for drug children and it seems to me that the funds should be spent on them.

4. Federal law concerning "reasonable efforts" should be amended to make absolutely clear that children should not be left with drug-addicted parents who cannot or will not care for them. Some drug-using parents are able to care for their children, at least with social service support. But most of their children remain at great risk while they stay at home. In 1987, of New York's child-abuse fatalities involving children previously known to the authorities, about three-quarters were alcohol or drug-related.[11] Hundreds of others suffer injuries short of death.

We must face the implications of the mother's addiction--and our inability to break her habit. If parents cannot care for their children, the children should be removed from their care and placed in foster care. When necessary, these children should be freed for adoption.

This will require overhauling state and federal foster care and adoption laws which have been routinely misinterpreted to preclude early removal of these children. (Of course, one can hope that these laws will be interpreted differently, but the fastest and most effective reform would come from a simple revision that emphasizes the need to remove some children from their parent's custody.)

I would recommend a relatively simple change: merely amend the "reasonable efforts" provisions of

---

[11] Memorandum to Stanley Brezenoff, First Deputy Mayor, New York City, from William J. Grinker, Human Resources Administrator, March 31, 1988, "Activities of the HRA Internal Fatality Review Panel during Calendar Year 1987," p. 3. It appears that about two-thirds were drug-related.

section 427 of the Social Security Act to make clear that, in appropriately severe cases, removal and even termination are "reasonable" at any stage of the proceeding.

5. Finally, we need a major research and demonstration effort that enables states to learn how best to deliver child protective and child welfare services. The present patchwork of federal programs—with often inconsistent eligibility and programmatic requirements—makes state and local innovation difficult, if not impossible. As I have described, the system faces three major problems:

(a) the inability to deliver effective prevention/treatment services,

(b) the inability to provide high quality and nurturing foster care over the long term, and

(c) the inability to make hard decisions about the future of children.

We need to mount a welfare reform-like experiment that allows five or ten states to obtain waivers of selected federal requirements so that they can restructure their programs to meet the rapidly changing needs of their clients. Like the work and job training programs of the 1980s, these efforts should be carefully and rigorously evaluated, to see what works—and what does not. Such an experiment/waiver program could also provide a five percent increase in funding for the participating states to serve as an added incentive to improve programs.

* * *

Meeting these twin challenges will not be easy. Making it easier to terminate parental rights is sure to be controversial, and may come only with the active support of the disadvantaged communities most affected. Similarly, the restructuring of foster care into a long-term, supportive environment will require a level of administrative commitment and capability that has too often eluded foster care agencies. But if we are to meet the needs of crack children, we cannot avoid facing these issues.

Chairman MILLER. Thank you. Dr. Blume.

STATEMENT OF SHEILA B. BLUME, MD., C.A.C., MEDICAL DIRECTOR, ALCOHOLISM, CHEMICAL DEPENDENCY AND COMPULSIVE GAMBLING PROGRAMS, SOUTH OAKS HOSPITAL, AMITYVILLE, NY

Dr. BLUME. First I'd like to thank the committee for inviting me here. I think I can speak for people like myself who have devoted our careers and our lives to helping women in need. We really appreciate the focus that you and your committee have continually put on this not very glamorous, not very attractive area of our nation's problems, which is the pregnant alcohol and drug abusing woman.

I began my interest in this field in 1962, when I began my career in psychiatry in a state hospital, started working with alcoholic women, and helped found the first alcoholism treatment service for women in New York State.

Just like Dr. Tuckson, in any program that I headed, a pregnant woman jumped any waiting list or any kind of bureaucratic or any other kind of barrier. We hung onto those women as long as we could and stuck with them and followed them very carefully. There is a young man I know in college today who was born while his mother was a patient in our unit.

I'm sorry to say that this interest in pregnant women and their problems is not as widespread as we would hope it would be, and that there are formidable barriers to women who are pregnant and who are in need of chemical dependency treatment.

Although I rejoice in listening to Kathleen's story and in her recovery, I weep at the number of opportunities that were missed when she had all those children, and was in obstetric care, and nobody picked up her problem and nobody intervened with her and nobody offered her what she needed.

We miss those opportunities every single day when women are in obstetric care and they are not screened appropriately, especially for alcohol problems. I did a small pilot study for the National Institute on Alcohol Abuse and Alcoholism a few years back, in which I visited a number of obstetric practices of different kinds across the country to look into exactly how women were being screened for alcohol problems.

We were already doing a whole lot of educating women that drinking during pregnancy could harm their fetus, and that the research is clear and it's known; there's no question about it. We now have little microscopic warning labels on bottles of alcoholic beverages. If you can read small print well, you can see them.

But are we doing the job of identifying women who do have problems, intervening with them, getting them the treatment they need, following up? The answer to that, unfortunately, is no. Except for the few programs that have been established recently by OSAP, (we'll hear about one of them in the next panel,) this is not being done. I cannot agree more with Dr. Tuckson that we need a systematic way to do this screening and intervention.

It should not be left to the interest of one individual or one program or one crusader, because when that crusader moves on, the

program collapses. It has to be systematically part of what our health care system cares about and does routinely.

We are very concerned about the nation's cocaine problems. Let me just say that I started and worked in the New York State system for 20 years. I ended my career as the state commissioner for alcoholism. So, like Dr. Tuckson, I've been in the public policy seat. I'm now in the private sector again treating chemically dependent women like Kathleen. Alcohol, other drugs, some one drug, most in combination, and sometimes pregnant.

Pregnancy is the best time to treat an alcoholic woman or a chemically dependent woman. The incentive to have the best, healthiest possible infant is a tremendous motivator for treatment. Throwing such a woman in jail where she will get no treatment, no incentive, and not very good nutrition and not very good handling, is the opposite of what we should be doing.

In my written testimony I have gone through some of the facts about chemical dependency and women, including the fact that women are more sensitive to alcohol than men. Research has been accruing to show us that women absorb more of the alcohol that they drink. We women lack an equal level of the enzyme ADH that men have in their stomachs. ADH breaks down alcohol before it ever gets into the bloodstream. We also have a lower water content in our bodies than men so the alcohol we do absorb is less diluted.

There are many facts about women's sensitivity to alcohol that are not well-known to the public, and certainly not well-known to women of childbearing years who need this knowledge if they're going to have the healthy babies that they want.

There is plenty of research about the incidence and prevalence of alcohol problems in women of childbearing age. We know that it is not only a poverty problem, although it's certainly common enough in poor populations. It cuts right across socioeconomic strata. For example, Andrea Halliday and her group from Harvard published a study in 1986, in which she looked at two private obstetric-gynecological practices. She studied women with an average age of 31, middle class educated women, and screened them for alcoholism. Twelve percent of the women coming in for routine care satisfied a diagnosis of alcoholism. What obstetric and GYN practice that you know do that? Very few. It depends on the interest of the leader of that practice, and yet that screening should go on in every practice in this country.

I think that Congress can help us, you mentioned with incentives. There is nothing the health care system responds to so well as incentives, financial and organizational incentives.

If you look at the trends for alcohol consumption in the nation as a whole, there has been a decrease in the average per capita alcohol consumption, and that's marvelous. But before we begin to feel comfortable about that, we have to look at the fact that although in general alcohol consumption is decreasing, consumption is increasing in the population we're interested in here, which is young adults, both male and female. These are the child bearers of our society.

Also we can't sit back and say we're concerned about the "drug" problem. It's the alcohol and other drug problem. I've also included with my written testimony some material about nicotine. Alcohol

is our favorite drug in this society. It's our most used and abused drug, and nicotine comes second. Nicotine also has a deleterious effect on birth outcomes, and there is an association between heavy smoking, alcohol use and other drug use.

We have to educate our young women about this sensitivity to alcohol, about the effects of alcohol on their bodies, about what are risk factors for them, and we have to start very young and we have to continue right through the life cycle.

Women who do develop alcoholism have very particular problems that differ from men's. Not only does the disease move faster in women and create the late stage physical problems like cirrhosis of the liver, anemia, and gastrointestinal problems more rapidly, but women are also deterred from getting treatment by a special stigma that our society lays upon them.

I think Kathleen could tell us very personally about what it feels like. Not only do we look down on women who have alcohol and drug problems as weak-willed and ineffective, but there is a strain in our society's thinking, going back as far as the ancient Romans and the Israelites, that tells us that women who drink are loose women, are promiscuous. We have these inaccurate sexual stereotypes that drive the ordinary alcohol and drug dependent woman underground.

Furthermore, it makes them considered acceptable targets for sexual abuse, very common in the woman that we treat, including the middle class women at my particular institution. Many of them have this history.

I cited one study in the written testimony and there's another published in 1982, that looked at attitudes about rape. It showed that if the rapist is intoxicated he is found less responsible for the crime, while if the victim is intoxicated, she is found more to blame for the rape. That is what we think in this society. It invites and has given us a documented high rate of sexual abuse among women who have this problem.

Both the stigma and the victimization add to the already formidable barriers that face chemically dependent women who seek treatment. Added to those we've already heard is the lack of child care for women who need inpatient treatment. You can't concentrate on getting well when you're worried about what's happening to your kids.

One other barrier has not been mentioned, which is a lack of insurance coverage. Many people who have health insurance coverage on the job for themselves and their families find that when they need treatment for chemical dependency, they're on their own and they often can't afford it.

These are all areas in which the Congress can help. I thank you so much for hearing us.

[Prepared statement of Sheila B. Blume follows:]

PREPARED STATEMENT OF SHEILA B. BLUME, M.D., C.A.C., MEDICAL DIRECTOR, ALCOHOLISM, CHEMICAL DEPENDENCY AND COMPULSIVE GAMBLING PROGRAMS, SOUTH OAKS HOSPITAL, AMITYVILLE, NY

THANK YOU FOR THE OPPORTUNITY TO TESTIFY THIS MORNING. I AM SHEILA B. BLUME, M.D., C.A.C., MEDICAL DIRECTOR OF ALCOHOLISM, CHEMICAL DEPENDENCY AND COMPULSIVE GAMBLING PROGRAMS AT SOUTH OAKS HOSPITAL IN AMITYVILLE, NEW YORK, CLINICAL PROFESSOR OF PSYCHIATRY, AT THE STATE UNIVERSITY OF NEW YORK AT STONY BROOK AND DIRECTOR OF THE SOUTH OAKS INSTITUTE OF ALCOHOLISM AND ADDICTIVE BEHAVIOR STUDIES. I HAVE BEEN ACTIVE IN THE FIELD OF ALCOHOLISM FOR 28 YEARS AND SERVE ON THE BOARDS OF THE DIRECTORS OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE, THE CHILDREN OF ALCOHOLICS FOUNDATION AND THE NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE. I AM ALSO CHAIRMAN OF THE PUBLIC POLICY COMMITTEE OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE, HOWEVER TODAY I SPEAK FOR MYSELF.

ALTHOUGH THE CRACK EPIDEMIC AND COCAINE AFFECTED BABIES HAVE DRAWN A GREAT DEAL OF RECENT MEDIA ATTENTION, WE MUST NOT FORGET THAT WE STILL HAVE A HORRENDOUS DRUG DEPENDENCE PROBLEM IN WOMEN IN THIS COUNTRY WHICH INVOLVES TWO LEGAL DRUGS: ALCOHOL (OUR NATION'S FAVORITE DRUG - NUMBER ONE IN BOTH USE AND ABUSE) AND NICOTINE, OUR SECOND FAVORITE. BOTH OF THESE DRUGS AFFECT THE GROWTH AND DEVELOPMENT OF THE FETUS. THE FETAL ALCOHOL SYNDROME REMAINS ONE OF THE TOP THREE CAUSES OF MENTAL RETARDATION DUE TO BIRTH DEFECT IN AMERICA, AND IS THE ONLY ONE OF THESE THREE CAUSES THAT IS COMPLETELY PREVENTABLE. CIGARETTE SMOKING DURING PREGNANCY HAS BEEN SHOWN TO CAUSE DECREASED BIRTH WEIGHT IN INFANTS. I WILL ATTACH SOME MATERIALS ABOUT WOMEN AND NICOTINE DEPENDENCE TO THIS TESTIMONY, BUT WILL CONCENTRATE THIS MORNING ON ALCOHOL.

WOMEN ARE MORE SENSITIVE TO ALCOHOL THAN MEN. FOR YEARS WE HAVE NOTICED THAT THE DISEASE OF ALCOHOLISM PROGRESSES MORE RAPIDLY IN WOMEN AND THAT WOMEN DEVELOP THE LATE STAGE COMPLICATIONS OF THE DISEASE FASTER AND WITH A LOWER ALCOHOL INTAKE WHEN COMPARED TO MEN. WE KNEW THAT THE LIGHTER WEIGHT AND LOWER WATER CONTENT IN WOMEN'S BODIES MEANS THAT THE ALCOHOL THEY CONSUME WILL BE LESS DILUTED. BUT NEW EVIDENCE HAS NOW COME TO

LIGHT THAT SHOWS US THAT WOMEN ALSO ABSORB MORE OF THE ALCOHOL THEY DRINK. COMPARED TO MEN, NORMAL WOMEN HAVE SIGNIFICANTLY LESS OF AN ENZYME THAT BREAKS DOWN ALCOHOL IN THEIR STOMACHS. ALCOHOLIC WOMEN HAVE ESSENTIALLY NONE OF THIS ENZYME, AND SO THEY ABSORB EVEN MORE (1). PUT THIS ALL TOGETHER AND THE RESULT IS THAT A STANDARD DRINK OF AN ALCOHOLIC BEVERAGE (A SHOT OF LIQUOR, A CAN OF BEER, A GLASS OF WINE) WILL HAVE FAR MORE DESTRUCTIVE EFFECT IN A WOMAN THAN IN A MAN. ADD TO THAT THE FACT THAT ALCOHOL ENTERS EVERY CELL OF THE HUMAN BODY AND EASILY CROSSES THE PLACENTA TO ENTER EVERY CELL OF THE DEVELOPING FETUS, AND THE STAGE IS SET FOR HUMAN TRAGEDY.

ALCOHOL PROBLEMS IN WOMEN CUT ACROSS ALL ETHNIC AND SOCIOECONOMIC GROUPS. FOR EXAMPLE, ANDREA HALLIDAY AND HER COLLEAGUES AT HARVARD FOUND THAT 12% OF 158 MIDDLE CLASS WOMEN OF CHILDBEARING AGE WHO WENT FOR ROUTINE GYNECOLOGICAL CARE WERE ALCOHOLICS (2). A STUDY AT JOHNS HOPKINS UNIVERSITY HOSPITAL, WHICH INCLUDED MANY DISADVANTAGED PATIENTS, FOUND A RATE OF ALCOHOL ABUSE OF 12.4% IN BOTH OBSTETRICS AND IN GYNECOLOGY INPATIENTS (3). THIS POINTS UP THE URGENT IMPORTANCE OF SYSTEMATIC SCREENING AND REFERRAL FOR ALCOHOL PROBLEMS IN OBSTETRIC PRACTICE (AS WELL AS ALL OTHER MEDICAL CARE). UNFORTUNATELY THIS IS NOT COMMONLY DONE AT PRESENT.

TRENDS IN ALCOHOL USE FOR THE NATION AS A WHOLE HAVE BEEN TOWARD A LOWER PER CAPITA CONSUMPTION (4). HOWEVER, BEFORE WE DERIVE ANY FEELING OF SECURITY FROM THIS TREND WE SHOULD ALSO NOTE THAT THE OVERALL DECREASE HAS BEEN COMBINED WITH AN INCREASE IN HEAVY DRINKING AMONG YOUNG ADULTS, BOTH MALE AND FEMALE (4). FOR WOMEN, THIS AGAIN MEANS THOSE OF CHILDBEARING AGE.

THE NEED TO EDUCATE OUR YOUNG WOMEN ABOUT THEIR SENSITIVITY TO ALCOHOL IS URGENT. YET MOST YOUNG PEOPLE DERIVE THE BULK OF THEIR KNOWLEDGE ABOUT ALCOHOL FROM ONE EVER-PRESENT SOURCE: ADVERTISING. BETWEEN THE AGES OF 2 AND 18 THE AVERAGE AMERICAN CHILD SEES SOMETHING LIKE 100,000 BEER COMMERCIALS (5). IN RECENT YEARS THE ALCOHOLIC BEVERAGE INDUSTRY HAS TARGETED WOMEN AS A GROWTH MARKET (6), YET VERY LITTLE TARGETED PREVENTION

31-228 0 - 90 - 3

WORK IS BEING DONE WITH GIRLS OR YOUNG WOMEN. THE "WOMAN TO WOMAN" PROGRAM OF THE ASSOCIATION OF JUNIOR LEAGUES, AND THE PROGRAMS OF THE NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE ARE AMONG THE VERY FEW. IN TERMS OF COMPARATIVE RESOURCES, WE ARE ROWING UP THE MIGHTY MISSISSIPPI RIVER IN A DINGHY. HERE IS A PLACE THE CONGRESS CAN REALLY HELP.

WOMEN WHO DO DEVELOP ALCOHOLISM HAVE PARTICULAR PROBLEMS WHICH DIFFER FROM MEN'S. THEY BEAR A VERY SPECIAL SOCIETAL STIGMA. NOT ONLY ARE THEY LOOKED DOWN UPON AS FAILURES, BUT THIS SOCIETY ALSO MAINTAINS A DEEPLY-HELD STEREOTYPE, DATING BACK TO THE ANCIENT ROMANS AND ISRAELITES, THAT WOMEN WHO DRINK ARE PROMISCUOUS (7). BECAUSE OF THIS STEREOTYPE WOMEN WHO DRINK ARE CONSIDERED ACCEPTABLE TARGETS OF SEXUAL ABUSE IN AMERICAN SOCIETY. FOR EXAMPLE, A 1982 STUDY OF RAPE SHOWED THAT SOCIETY FINDS A RAPIST WHO IS INTOXICATED TO BE LESS RESPONSIBLE FOR THE RAPE WHILE A VICTIM WHO IS INTOXICATED IS CONSIDERED MORE TO BLAME (8). THERE IS AN ENTIRE BODY OF RESEARCH ON SEXUAL ABUSE AND VICTIMIZATION AS BOTH A PRECURSOR (9) AND A RESULT (7) OF WOMEN'S ALCOHOLISM AND DRUG DEPENDENCE.

TODAY WE ARE FACED WITH YET ANOTHER FORM OF VICTIMIZATION OF ALCOHOL AND DRUG DEPENDENT WOMEN. THAT IS THE CRIMINAL PROSECUTION OF THESE SICK WOMEN FOR SO-CALLED "PRENATAL CHILD ABUSE," OR FOR DELIVERING CONTROLLED SUBSTANCES TO A MINOR THROUGH THE UMBILICAL CORD. THE SUBSTITUTION OF CRIMINAL PROSECUTION FOR PREVENTION AND TREATMENT IS AN UNCONSCIONABLE PUBLIC POLICY. WE LOOK TO CONGRESS FOR HELP IN REVERSING THIS TREND (SEE ATTACHED).

BOTH STIGMA AND VICTIMIZATION ADD TO THE FORMIDABLE BARRIERS ALREADY FACING CHEMICALLY DEPENDENT WOMEN WHO SEEK TREATMENT. (TODAY WE TEND TO SPEAK OF "CHEMICAL DEPENDENCY" BECAUSE OF THE VERY COMMON CO-OCCURRENCE OF ALCOHOL AND OTHER DRUG DEPENDENCE IN WOMEN) (10). THE FOREMOST BARRIERS, IN ADDITION TO STIGMA, ARE THE LACK OF CHILD CARE AND INADEQUATE INSURANCE COVERAGE. HERE AGAIN WE LOOK TO THE CONGRESS FOR HELP.

I SINCERELY HOPE THAT THESE HEARINGS WILL FOCUS THE ATTENTION OF THIS COMMITTEE, THE CONGRESS AND OF THE AMERICAN PEOPLE ON URGENT AND THE IMPORTANT WORK THAT NEEDS TO BE DONE IN THE PREVENTION AND TREATMENT OF CHEMICAL DEPENDENCY IN WOMEN. WE HAVE ALREADY FALLEN BEHIND. PLEASE HELP US CATCH UP.

(I HAVE ATTACHED SOME REFERENCE MATERIALS AND A BIBLIOGRAPHY TO THIS TESTIMONY).

THANK YOU.

LIST OF ATTACHMENTS

1. Blume SB,, Women and Alcohol: a Review, Journal of the American Medical Association, Sept. 19, 1986, is retained in committee files.
2. Blume SB, Alcohol and Drug Problems in Women: Old Attitudes, New Knowledge, Chapter from a 1990 book (reference number 7), is retained in committee files.
3. Policy statement on chemically dependent women and pregnancy, American Society of Addiction Medicine.
4. Chemical Dependence in Pregnancy: Latest Target for Abuse, ASAM News, September—October, 1989.
5. Position paper on tobacco, American Medical Women's Association.
6. Blume SB, Dual Diagnosis: the Co-Occurrence of Psychoactive Substance Dependence with other Psychiatric Disorders, is retained in committee files.

BIBLIOGRAPHY

1. Frezza M, DiPadova C, et al, High Blood Alcohol Levels in Women, New England Journal of Medicine, 322:95-99, 1990.

2. Halliday A, Bush A, et al, Alcohol Abuse in Women Seeking Gynecological Care, Obstetrics and Gynecology, 68:322-326, 1986.

3. Moore RD, Bone LR, et al, Prevalence, Detection and Tratment of Alcoholism in Hospitalized Patients, Journal of the American Medical Association, 261:403-407, 1989.

4. National Institute on Alcohol Abuse and Alcoholism, Seventh Special Report to the U.S. Congress on Alcohol and Health, 1990.

5. Postman N, et al, Myths, Men and Beer: an Analysis of Beer Commercials on Broadcast Television. AAA Foundation for Traffic Safety, Falls Church, VA, 1987 (cited by NCADD in its Fact Sheet on Alcoholism and Other Alcohol-related Problems Among Children and Youth, 1988.)

6. Jacobson M, Hacker G, Atkins R, The Booze Merchants, A Report from the Center for Science in the Public Interest, Washington, DC, 1983.

7. Blume SB, Alcohol and Drug Problems in Women: Old Attitudes, New Knowledge, in: Milkman HB and Sederer LI (eds), Treatment Choices for Alcoholism and Substance Abuse, Lexington Books, Lexington, MA, 1990. (Copy attached).

8. Richardson D, Campbell J, The Effect of Alcohol on Attributions of Blame for Rape, Personal and Social Psychology Bulletin, 8:468-476, 1982.

9. Winfield I, George LK, et al, Sexual Assault and Psychiatric Disorders Among a Community Sample of Women, American Journal of Psychiatry, 147:335-341, 1990.

10. Blume SB, Dual Diagnosis: The Co-Occurrence of Psychoactive Substance Dependence with Other Psychiatric Disorders, Clinical Update Vol. 2, No. 3, South Oaks Hospital, Amityville, NY, Dec., 1989. (Copy attached).

ASAM NEWS

American Society of Addiction Medicine
formerly American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD)

Vol. IV, No. 5 **September - October 1989** Published Bimonthly

Chemical Dependence in Pregnancy: *Latest Target for Abuse*

by Sheila B. Blume, MD

In Sanford, Florida, a judge finds a 23-year-old cocaine dependent woman guilty of delivery cocaine to her two infants via the umbilical cord, under a criminal drug-dealing statute.

In South Dakota, an American Indian woman is jailed to keep her from drinking during pregnancy.

In California, a district attorney announces his intention to prosecute mothers whose newborns test positive for illicit drugs on a urine screen.

These stories are becoming commonplace in America today. Has our society, unable to prevent alcoholism and other drug dependence in women, unable to make adequate treatment available, decided to fall back on criminalizing and punishing as substitutes for care?

(continued on page 7)

GUEST EDITORIAL

Chemical Dependence in Pregnancy:
(cont'd from p. 1)

This increasing use of prosecution has been accompanied by proposals, at state levels, to redraft child abuse legislation in order to include "prenatal child abuse." Prenatal child abuse would then include psychoactive substance use in pregnancy. Such a redefinition of child abuse would require us to report, without her consent, any chemically dependent pregnant patient in our practices or programs.

Dr Sheila Blume

Concern about these and other local instances of abuse prompted ASAM to join, with more than a dozen other concerned organizations, in a coalition on chemically dependent women and their children. The coalition meets regularly in Washington, convened by the National Council on Alcoholism (NCA).

These developments have also prompted ASAM's *Policy Statement on Chemically Dependent Women and Pregnancy*, which was passed by our board of directors on Sept. 25 (see p. 6, adjacent to this page).

Now that ASAM has adopted this policy, it is up to all of us who care about the victims of chemical dependency to help bring these principles to our home states and local communities. Please take a moment. Read the policy statement. Do you know what activity is currently under way in your community? Are there government agencies or groups who believe in good faith that these punitive measures are a legitimate method of prevention? Are there others advocating for improved services? Can you lend your clinical expertise and your influence to support enlightened policies?

We all work in different settings. Some can advocate for programs that allow the newborn infant of a chemically dependent mother to remain with her in treatment. Some can take part in discussions to develop coordination of perinatal and chemical dependency treatment. Some can encourage research. Some can speak to our colleagues in law enforcement, the judiciary, and the legislature.

As the pendulum of societal attitude continues to swing between permissiveness and punitiveness, we must continue to be the advocates for humane care.

Dr. Blume is Medical Director of Alcoholism, Chemical Dependency, and Compulsive Gambling Programs at South Oaks Hospital, Amityville, New York. She is also Chair of the ASAM Public Policy Committee.

ASAM Policy Statement on Chemically Dependent Women and Pregnancy

Background of the Problem

Because of the adverse effects on fetal development of alcohol and certain other drugs (including nicotine, cocaine, marijuana, and opiates) the chemically dependent woman who is pregnant or may become pregnant is an especially important candidate for intervention and treatment. Similarly, prevention programs should target all women of childbearing age.

Recently, public concern for preventing fetal harm has resulted in punitive measures against pregnant women or women in the postpartum period. These measures have included incarcerating pregnant women in jails to keep them abstinent and the criminal prosecution of mothers for taking drugs while pregnant and thereby passing those substances to the fetus or newborn through the placenta.

The American Society of Addiction Medicine is deeply committed to the prevention of alcohol- and other drug-related harm to the health and well-being of children. The most humane and effective way to achieve this end is through education, intervention, and treatment. The imposition of criminal penalties solely because a person suffers from an illness is inappropriate and counterproductive. Criminal prosecution of chemically dependent women will have the overall result of deterring such women from seeking both prenatal care and chemical dependency treatment, thereby increasing, rather than preventing, harm to children and to society as a whole.

Policy Recommendations

The American Society of Addiction Medicine supports the following policies:

1. Prevention programs to educate all members of the public about the dangers of alcohol and other drug use during pregnancy and lactation. These should include:

- Age appropriate school-based education throughout the school curriculum.
- Public education about alcohol and other drug use in pregnancy and lactation, including health warning labels and posters as well as radio and television messages, educational programs and written materials.
- Prenatal education about alcohol and other drugs for all pregnant women and significant others, as part of adequate prenatal care.
- Professional education for all health care professionals, including education of obstetricians and pediatricians in the care of chemically dependent women and their offspring.

2. Early intervention, consultation, and counseling programs specifically designed to reach chemically dependent women.

- Screening for alcohol and other drug problems in all obstetric care services, as well as in all medical settings.
- Adequate case finding, intervention, and referral services for women identified as suffering from chemical dependency.

3. Treatment services able to meet the needs of chemically dependent women.

- Appropriate and accessible chemical dependency treatment services for pregnant women and women of childbearing age and their families, including inpatient and residential treatment. Services to care for the children and newborns of these patients should be provided. Without adequate child care arrangements, chemically dependent women are often unable to engage in the treatment they need.
- Adequate facilities for the outpatient and aftercare phases of treatment for chemically dependent women.
- Adequate perinatal care for chemically dependent women in treatment, sensitive to their special needs.
- Adequate child protection services to provide alternative placement for infants or children of persons suffering from chemical dependency who are unable to function as parents, in the absence of others able to fulfill the parent role.

4. Research:

- Basic and clinical research on the effects of alcohol and other drugs used during pregnancy.
- Model programs, with evaluation component, for case finding intervention and treatment of chemically dependent pregnant women, and for case finding, intervention, and treatment of infants and children affected by maternal alcohol and/or other drug use.

5. Law enforcement:

- State and local governments should avoid any measures defining alcohol or other drug use during pregnancy as "prenatal child abuse," and should avoid prosecution, jail, or other punitive measures as a substitute for providing effective health services for these women.

6. Preservation of patient confidentiality:

No law or regulation should require physicians to violate confidentiality by reporting their pregnant patients to state or local authorities for "prenatal child abuse."

◆

Adopted by ASAM Board of Directors Sept. 25, 1989

Copies of these and other ASAM position statements are available free by request, in writing, from:

American Society of Addiction Medicine
12 West 21st Street,
New York, NY 10010

AMWA American Medical Women's Association, Inc.

801 NORTH FAIRFAX STREET • SUITE 400 • ALEXANDRIA, VA 22314 • TELEPHONE (703) 838-0500
REPRESENTING WOMEN IN MEDICINE SINCE 1915

POSITION PAPER ON TOBACCO

PART I - BACKGROUND

A. General Health Effects

The Surgeon Generals' reports on smoking and health have united the medical profession in its recognition of the adverse health effects of smoking, both for active smokers and for involuntary or passive smokers. There is a vast list of diseases caused or exacerbated by smoking led by heart and vascular disease, chronic lung disease and lung cancer. Now many other cancers are also known to be associated with smoking. These include cancers of the larynx, oral cavity, hypopharynx, esophagus, bladder, and pancreas. Furthermore, the prevalence of cancers of the kidney, cervix, liver, ureter, and rectum is greater among smokers. Besides coronary heart disease and stroke, smokers are more prone to peripheral vascular disease, aortic aneurysms, vascular impotence (men), chronic bronchitis, asthma and pneumonia. Also, those who smoke are more susceptible to influenza and colds, peptic ulcer disease, pancreatitis, reflux esophagitis, inguinal hernias, periodontal disease, headache, Legionnaire's disease, and subclinical vitamin C deficiencies.

B. Reproductive Health Effects

Smoking has a particularly damaging effect on fertility and reproduction in women. It is associated with early menopause, an increased risk of post-menopausal osteoporosis, reduced fertility, increased menstrual abnormalities, and impaired lactation. Male smokers have reduced sperm counts and more abnormal sperm. In pregnant women, smoking causes fetal hypoxia, premature births, spontaneous abortions and stillbirths, reduced birth weight (undernutrition), and an increased incidence of neonatal deaths, including sudden infant death syndrome.

C. Effects of Passive Smoking

Nonsmokers also suffer. Children of smoking parents have an increased incidence of bronchitis and pneumonia, wheezing and asthma, colds and middle ear infections, retarded lung growth and eventual tobacco addiction, as they themselves begin to smoke. In adults, passive smoking frequently causes eye irritation, headache, nasal symptoms, cough, angina, allergies and asthmatic attacks. Less commonly but more devastating is lung cancer, a consequence of passive smoking evidenced in nonsmokers living with smoking spouses.

D. Effects of Smokeless Tobacco

The health consequences of smokeless tobacco include tooth and gum diseases, all the effects of systemic nicotine absorption, including addiction, as well as carcinoma of the oral cavity, with death from secondary metastasis.

E. Costs of Tobacco Usage

Smoking workers suffer more sick days, reduced productivity, and increased health care costs compared with non-smokers. The cost of tobacco products also represents a significant financial drain on the family budget. Furthermore, cigarettes are the leading cause of household fires, resulting in homelessness, injuries, and fatalities.

F. Smoking in Women and Girls

During the past twenty years the death rate from lung cancer in women in the United States has been steadily increasing and in 1986 surpassed the death rate from breast cancer. The prevalence of male smokers has decreased dramatically over the last two decades, while the prevalence of female smokers has remained essentially unchanged. A higher proportion of new smokers are female, especially teenagers. False advertising is pointedly directed toward women, emphasizing an association between cigarettes and slimness, beauty, sex appeal, and pleasurable sporting activities.

PART II - AMWA AGENDA

The American Medical Women's Association (AMWA) is working toward the elimination of tobacco use, because of the enormous drain it has placed on the well-being of the population, both smokers and involuntary smokers, on our health care institutions, and on our economic and ecological resources as a nation and as a planet.

We place particular emphasis on women because of the present unfortunate trends in their smoking habit. Our efforts are directed toward prevention, cessation, and the promotion of a smoke-free society.

A. Individual Commitment

As physicians, we recognize the responsibility of our profession to promote the health of our patients. Therefore, each physician member will work to prevent and stop smoking among her patients in a manner appropriate to her type of practice, and work to promote clean indoor air in her own office. This shall include maintaining smoke-free waiting rooms, physicians' offices, examining rooms and laboratories associated with the practice, as well as encouraging and supporting the development of smoke-free hospitals and health care institutions.

B. Prevention

1. We recommend vigorous anti-smoking educational programs in the schools, particularly concentrating on the pre-adolescent age group, since it is at this stage that future smoking behavior is determined. AMWA is developing and implementing such programs for use by members and other interested organizations.

2. We support a ban on all cigarette advertising, since it has been shown to promote the initiation of smoking in children, rather than just influencing brand loyalty as the tobacco companies claim.

3. We strongly endorse an active antismoking advertising campaign, featuring role models admired by young people urging a healthy, smokefree lifestyle.

4. We oppose the distribution of free cigarettes, as they all too often fall into the hands of impressionable young people. Similarly, we oppose the sale of tobacco products to children and sales from unsupervised vending machines. Likewise we are against the sale of candy cigarettes which encourage preschool children to role play the mannerisms of smoking.

5. We support a substantial increase in the excise tax on tobacco products, which would increase the price to a level high enough to discourage their purchase by children and young adults.

C. Cessation

1. AMWA has gathered and will expand upon a bank of information containing successful cessation techniques which are specialty specific for physicians in various health care roles.

2. We urge employers to encourage workers to quit smoking by instituting clean indoor air policies and offering and supporting cessation programs.

3. We support the concept of reduced life and health insurance premiums for non-smokers and ex-smokers, as well as for the insurance of houses, office buildings, and hospitals where there is no smoking.

D. Smoke-free Society

1. We support legislation and policy changes which promote a smoke-free environment for all workers.

2. We support the public's right to a smoke-free environment, including health care institutions, transportation conveyances, places of public entertainment, restaurants, grocery stores, post offices, banks, and all schools.

3. We oppose the sponsorship of sports, entertainment, and cultural events by tobacco companies, because such exposure associates their products with healthy, wholesome activities. We particularly deplore the intense involvement of tobacco companies in minority programs, and the industry's marketing efforts targeted to recruit smokers among the same population that they purport to assist.

4. We will work to get anti-smoking information into magazines, especially those aimed at women, adolescents, and children. We vigorously oppose cigarette advertisements in such magazines.

5. We will work to raise the priority of smoking as a health issue on the agenda of all women's groups.

6. We support cessation of federal and state government subsidies to tobacco growers. We encourage programs aimed at helping tobacco farmers to find alternative crops and workers in the tobacco industry find other employment.

7. We oppose the exportation of tobacco products and their associated diseases to overseas markets.

1763/31

Chairman MILLER. Thank you very much.

Let me just ask, if I can follow along with you, in terms of the women that you treat, Amityville is a middle class, upper middle class area?

Dr. BLUME. Yes. We have a range of lower to upper middle class men and women.

Chairman MILLER. I just wonder if you might just—if you can help us in a description of these women. Have they sought treatment before, how isolated are they or aren't they? What have they done before they've come to see you?

Also, I would also be interested in your notion of how would you measure success?

Dr. BLUME. First, if we had our women's group from South Oaks Hospital sitting up in the front row here, you would not be able to tell them from the other spectators. They are young, they are middle aged, they are elderly, they are black, they are white. They come from a range of backgrounds and homes, but if you know them well there are certain similarities.

Many of them, like Kathleen, come from a family where there was alcoholism, often multi-generational, including the grandparental generation. They're often married to or living with men who have alcohol and drug problems. If we look at the genetic and environmental effects in etiology, we find the studies we have show that women are more sensitive to the environmental side of it than men.

Women are very influenced by the partner they live with in their pattern of alcohol and drug use. Many women are introduced to drugs and supplied with drugs by their marital partner, so we see that very commonly.

We always have family members participate, that's a key element in treatment, and we often find ourselves intervening with the husband or the spouse of a patient trying to get that person treatment, knowing that the family is not going to heal unless both partners and often the children get some help as well.

Just yesterday in a group a pregnant young woman who was leaving treatment today made a little thank you speech to the rest of the group and told us, as I mentioned to you earlier, that she felt blessed by the opportunity of bringing a healthy baby into the world, which would not have been if not for her treatment.

The fact that there are thousands of women out there without that opportunity breaks my heart, and I think it should break all of our hearts.

Chairman MILLER. How would you measure success, do you measure her as a success? Are you waiting six months or a year?

Dr. BLUME. She doesn't just go out there.

Chairman MILLER. I understand.

Dr. BLUME. She's going to be in continuing treatment with us. She has a good sponsor in Alcoholics Anonymous who will be with her as she leaves the hospital.

Chairman MILLER. How often will she have contact with you?

Dr. BLUME. She will be seeing us once or twice a week and at AA meetings most of the evenings. As she gains strength we will change her follow-up care.

Chairman MILLER. She will be seeing you twice a week and AA or at AA?

Dr. BLUME. Both.

Chairman MILLER. Both?

Dr. BLUME. She'll be coming to our after care clinic and she will be attending her meetings. We will give her as many sessions as she needs, but she's off to a very good start.

Chairman MILLER. How do you characterize your program, usual, unusual?

Dr. BLUME. Well, I'm sorry to say we're unusual in the fact that we look for and welcome pregnant women. I know that there have been reports, for example, Wendy Chafkin from Columbia University, has studied treatment accessibility for women with crack problems who were pregnant and found that they were unwelcome in many programs. So that's unusual.

Chairman MILLER. Let me ask the question then, Mr. Besharov said that programs were readily accessible to these women in New York, that's contrary certainly to what the select committee has been told and what our surveys show. What is it?

Dr. BLUME. I can only tell you what Dr. Chavkin found and that there's a lawsuit going now against a few facilities in New York City who were excluding pregnant women from their hospital detox services. So I'm afraid it's not as available as we wish it would be.

Chairman MILLER. We found that in our surveys, I mean from formal policies that refused to see women who are pregnant and substance abusers to informal policies that just don't accept Medicaid individuals or what have you.

Doug, how do you determine——

Mr. BESHAROV. I hope I didn't use the word "readily." It's always a question of whether the glass is half full or half empty. We'll get better numbers. I'd be glad to submit to the committee a written statement from New York City questioning Wendy's numbers.

Let me say what I think is happening here is that people see the very difficult problem of finding facilities for pregnant mothers involved. Here, there are liability concerns that really move this off the table.

For example, these are potentially, or at least they're viewed as potentially very litigious patients. Clinics are reluctant to take one of these pregnant mothers and offer any kind of service that might not work, or to offer any kind of blocker that could cause any kind of birth defect or that could be claimed to cause a birth defect.

So I think what we might be looking at here is the difference between programs that are willing to deal with pregnant women and programs that are willing to deal with mothers. That's not the same.

I really don't want to leave the impression that I'm saying that there's enough in the way of services, but let me just say in New York City the Department of Social Services has a rule that if the mother does not accept treatment services the case must be referred to the family court. Less than 20 percent of the drug related cases are referred to the family court. That means that those caseworkers are finding some treatment services. It's not the same as

saying it's a perfect one or that they're adequate, it's just that there's more out there than is commonly accepted or described.

Chairman MILLER. Those are the same workers that checked that all reasonable efforts have been made before they take the child out of home. That box gets checked on all those forms, you know.

Mr. BESHAROV. I'd be glad to discuss that issue. I think it's a difficult one. I just say that when we look at these programs, we do refer mothers to them. For example, New York City is about to spend $300 million a year to expand treatment services. That's the right direction.

Chairman MILLER. I understand that but, again, in the Select Committee when we look behind the referrals, what causes so much trouble is you can be referred to Dr. Blume's program, but what the referral means is you're now on the waiting list to get into the program, and that satisfies the criteria to keep you out of court or to keep you from child protective services or keep you from your child being taken away. You've been referred to a waiting list.

Mr. BESHAROV. There's a real tendency in this discussion to mix different kinds of addiction. I was addressing crack cocaine.

Chairman MILLER. However, you pick your addiction. Pick your addiction and then we'll find a waiting list for it, that's my concern.

Mr. BESHAROV. I think it's very different because the kind of program that Dr. Blume described and it's effectiveness, and we know it's effective, is in part because it's for treatment of alcohol addiction. I don't know, I would ask an open-ended question, if I may, whether the experience is the same for compulsive crack addicts, because they have very different kinds of addictions, which are much harder to treat.

Chairman MILLER. I understand that, but you take the client as they are. If you're pregnant and you're crack addicted, to stay out of the court system, you're referred to a program. The reference is nothing more than a waiting list.

If it's recognized by child welfare workers or probation officers and others as an effective program, the waiting list is only longer.

Mr. BESHAROV. I don't know how to answer this. There is an answer which is we can go count the cases and the waiting lists. I think the answer is that the glass is half full or half empty. There is treatment there, but it's not sufficient.

Clearly, Mr. Chairman, you agree that there is——

Chairman MILLER. It depends on whether you're thirsty or not thirsty whether the glass is any good to you.

Mr. BESHAROV. No, no. If you want to assert, sir, that there is no treatment out there——

Chairman MILLER. No, I don't want to assert that. In fact, I'll assert just the opposite that there's some very good treatment, except it's very inaccessible except for a very small number of people. That's what concerns me.

There's a lot of treatment mills out there that are running people through and picking up their insurance money, or keeping people out of court or out of criminal courts and what have you, and there's a lot of people who just have access to no treatment.

That's one of my concerns when we look at this particular population—with respect to women and to pregnant women—on whether or not, in fact, we have a model treatment system out there that can accept these individuals and start with treatment.

In fact, as we will hear later, there are successes, just like we have a success here in mainly alcohol treatment in the Amityville program. There are successes with crack cocaine, with cocaine, with heroin addiction.

Mr. BESHAROV. I hope we're not disagreeing, because I'm not saying that there is sufficient treatment. I might disagree with whether there is very, very little, but it is clearly not sufficient. I think the more important point is the one that you just made, which is that different kinds of addictions have very different success rates in terms of treatment.

If you talk about what the next steps are, it might be quite appropriate to talk about major expansions of the actual on-line treatment ability in, for example, alcoholism. For crack cocaine the answer is, as Dr. Tuckson suggested, much more understanding, much more research before really jumping ahead.

You know, it is not by accident that the only serious suggestion about treatment of crack cocaine is acupuncture. That is because no one has found anything else that really works. So I think it's very important to make these distinctions.

Chairman MILLER. Let me go back and let me throw this out because, Kathleen, I want you to come into this. That statement is what worries me in this discussion because it sort of leads to the notion, well nothing works here so let's take the babies away, throw the women in jail and we'll work this out because nothing works.

The question is really what are we going to measure as success. I mean, is it going to be lifetime abstinence, and if you can't achieve that, that's not success? I'm worried here about what our bench marks are. I mean, that's what we would like to achieve, but in terms of the population, how do we measure this?

You like to believe that you will be sober for six years and for 60 years and that your thinking will change so that you can pass that on to your daughter and to your son. I don't know if that measurement allows us to engage in real discussion of treatment and the notion that we're going to achieve the level of success that politicians want to invest in the program.

Dr. BLUME. May I just comment that we don't exclude cocaine users and crack users. The program that I run is not a pure alcoholism program. If we only had patients with alcoholism, we could go down to about 10 beds from nearly 100, and we'd be fine.

Many of our younger women do use crack and do use other forms of cocaine, and we confront that head on and it is not a hopeless situation. The fact that if you look in the research literature you find acupuncture, is because the treatment of crack addiction is new. It's part of this epidemic that came upon us really quite recently.

That should not be understood by the public to mean that nobody's getting any useful treatment for crack addiction because there aren't yet research papers on the subject. They're being

treated everywhere, and I'm sure in your facility, too, and they're doing very well.

We don't have the research yet to bring this all together, but please don't feel that there is nothing out there that'll help these people.

Ms. 'X'. I'd have to agree. I think if you look at what I went through, I went through a 30-day program. Well, I had been using drugs and alcohol since I had been 14 yeras old. I used after I got out of the 30-day program. Is that not a success? I think not.

I think when you look at what is successful and what isn't, it's not how many times the person relapses, but is the person learning other tools and techniques to deal with life stresses and are we helping to connect these people into resources that are going to help them better their lives and get better jobs and get better education, to continue on with their sobriety.

You know, one thing that we learn is it is one day at a time. I was asked a question yesterday in an interview, "Are you afraid and worried that you're going to fall off the wagon?" I said, "No, not at all, because I know today I am not using drugs and alcohol, but I have tools to deal with situations that come up."

In dealing with the crack problem, you know, it used to be once a heroin addict, always a heroin addict. If that had been the mindset when I went through treatment, as a matter of fact, when I went through the 30-day treatment center a lot of them didn't want to take heroin addicts, especially females with kids on medical assistance.

None of these drugs are hopeless, we just have to get a little better at what do we need to do to help these people. With the crack cocaine, I believe the biggest problem is the environment, especially since we're talking about women and children today. We're sending women that are in a social environment where crack is there. When we treat them for 30 days and send them back to the same environment, their chances of making it are not good.

You can almost bet they're going to use again, especially, with the point Dr. Blume had brought up about the dependency on men and the men using the drugs. I really believe that the answer is sober environments, sober placements where the women can live with the children and get the support services.

You're not going to fix this problem in a 30-day period, it takes a while. You've got to keep chipping away at it.

Chairman MILLER. Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

I think first of all I don't believe that there's anyone on this committee who thinks that women should be put in jail. I do think that there are some situations in which the child of a user is at risk, and that sometimes they have to be separated. You don't like that, you don't want to have to do that, but sometimes in order to protect the child it has to be done.

Would you agree with that, Dr. Blume?

Dr. BLUME. Oh, absolutely. Throughout this country we have a mandated child abuse and neglect reporting system, as you know very well, it's been your doing. We regularly make reports of child abuse and neglect and we help, when necessary, place people, and

we will help to get them back together when we can help the woman recover.

My comments were like Mr. Miller's in his opening statement, that what I see that troubles me so much is that; having failed or perceiving that we failed at preventing chemical dependency in women; having failed to make the treatment and intervention that they need available; there's now this punitive answer. Well, if we can't help them, (and we haven't even tried sufficiently helping them) let's punish them. That's what I'm against. I think if children are living with parents for whatever reason who can't parent them adequately, yes, they must be removed.

Mr. BLILEY. Thank you. How many cases of alcohol abuse are you aware of in which a newborn has been abandoned at a hospital?

Dr. BLUME. I can't respond with numbers to that. I'm sure it's a major problem and you may know more about it than I. It does exist. You have newborns who go through alcohol withdrawal born to women who have been drinking at a high level during pregnancy, and sometimes those women disappear.

Mr. BLILEY. Aren't there many more crack babies that are abandoned at hospitals, would you agree with that?

Dr. BLUME. Again, without numbers at my disposal, I can't answer it from a knowledge base of research. It would seem to me it's a common problem.

Mr. BLILEY. Dr. Besharov, would you care to take a crack at that?

Mr. BESHAROV. I sit on the fatality review panel of New City's Human Resources Administration and we review the death of every child previously known to the agency. Last year we reviewed the deaths of 140 children, and it is quite true that the problems are multidrug problems. (Polydrug is the technical term.) But our present child welfare concern is driven by this crack issue.

We have seen in those 140 cases a number of situations in which the mothers have abandoned newborns in the hospital. I just came from a meeting last week with Margaret Hagerty, we're on the panel together, and we had a mother whose baby died in the hospital and it was a week before she asked how the baby was. She gave birth and left, and it was a week before she asked, "How is my baby doing?"

I don't think every crack addict is a bad mother. Bad is even the wrong word, inadequate, but some are. I was very troubled by the suggestion before that all these children are removed haphazardly or just by checking a box. Nationally it's about 20 or 30 percent of the children who are removed. There is a very careful weighing of the danger to the child, I think, in most jurisdictions and the options available.

I think the system is trying very hard to identify those children who are in most danger in order to protect them, and it is the crack children, I think, who are in much greater immediate danger than the alcohol children.

Mr. BLILEY. Thank you very much.

Dr. Blume, how many of your patients who abuse illicit drugs voluntarily entered your treatment facility as opposed to those who entered because they were went through the justice system?

Dr. BLUME. There's a real difference between the men and the women we treat. Among women very few are referred in by either the drinking driver program or probation or other criminal justice systems. Among men the proportion is much higher.

Most women that we see, and I think it's true nationwide, are referred in because of two kinds of problems, family problems and health problems. They are referred in by members of their families who have been able to get help through self-help groups like Al-Anon, or through counseling, or they're referred in because they are feeling ill and it finally becomes apparent that there is something beneath the symptoms that has to do with chemical dependency.

Mr. BLILEY. Your statement, doctor, as well as your appendices feature a theme endorsing more specialized treatment programs. Would this mean that the more than 8,000 treatment centers currently in place ought to be eliminated for the sake of this goal?

Dr. BLUME. Heavens, no. I wouldn't eliminate one bed or one outpatient slot. We need every one we have in this country. I think what I said in my oral remarks was that we need better coordination with what we have.

In the study that I mentioned in one hospital that I shall not name, I introduced the head of the obstetric department to the head of the chemical dependency clinic. They were in the same large building and they had never met. There were precious few referrals from one to the other, although the chemical dependency treatment was seeing pregnant women, they were not coming through the referred route they should have come.

Mr. BLILEY. I'm glad to hear you say that because I have introduced legislation to require that localities have all of these services for pregnant mothers to be, for children's immunizations, for nutrition all in one location because in many instances the poor—in almost all instances—have transportation problems. If they've got to go all across town and have to wait everywhere they go, they get frustrated and they won't go.

Dr. BLUME. Often a referral means a little slip of paper with an address on it, and that's not a very effective method. I agree with you.

Mr. BLILEY. Thank you very much.

Chairman MILLER. Thank you. Mr. Levin.

Mr. LEVIN. Just a couple of quick questions to Mr. Besharov. You referred to the half full, half empty analogy. I don't understand its significance. I'm trying to figure out where people come from on this issue. Listening to the testimony I'm rather confused. What's the relevance of calling it half full or half empty?

Mr. BESHAROV. I thought I was trying to respond. In fact, I didn't understand the relevance of the chairman's question. I was trying to respond to what I thought was a statement that there was absolutely no or almost no treatment out there. There's a great deal of treatment, and even though it is clearly inadequate, there are many people out there providing treatment.

I was just trying to say that it's more than nothing, it's not sufficient, but it's certainly more than nothing.

Mr. LEVIN. I don't think the chairman said it was nothing, and Dr. Blume is right next to you.

Mr. BESHAROV. I hope I'm not in the middle of some kind of symbolic crusade. I don't know what the issue is. I truly do not understand. If you want me to say that there are inadequate services out there, I have said it a number of times.

I don't know what the issue is. I truly don't know either, sir.

Mr. LEVIN. So if you say it's clearly inadequate, that's kind of enough, isn't it?

Mr. BESHAROV. I don't know what——

Mr. LEVIN. What's the argument?

Mr. BESHAROV. I give.

Mr. LEVIN. What?

Mr. BESHAROV. I give up.

Mr. LEVIN. I don't want you to say anything you don't want to say. I'm trying to figure out what you're saying, and I mean that respectfully.

What I'm trying to figure out in this field, what are the real differences? When you say there's a great deal but they're clearly inadequate, maybe it isn't worth the argument unless you're emphasizing the great deal instead of the clearly inadequate.

Do you mean to do that? I mean, do you mean to emphasize the great deal of services instead of clear inadequacy? I don't think you really want to do that, right?

Mr. BESHAROV. No. I think what I mean to emphasize is that on the child welfare side of this problem, as opposed to the drug abuse side of this problem, on the child welfare side is where we make decisions about the welfare of children.

There are child protective programs that can make referrals to treatment programs, that do make referrals. Sometimes those referrals are successful, many times they are not. In those situations in which the referrals are unsuccessful, there is a present need to determine what's necessary for the children, not a year or two from now when some legislation might or might not pass.

I think that there are dedicated people out there working within a situation of some treatment services out there, finding that even with those treatment services some mothers cannot be reached in the time that makes sense for the child's welfare, and those children are being removed from the home. I think in most circumstances those are valid decisions, although as in everything there are overreactions and underreactions.

I think that is one of the challenges, I'm not really addressing the adequacy of drug treatment services, I'm worried about the child welfare side of it. In those circumstances where these children have been removed, we do have to face the question of whether we do some permanent decision making about their long-term welfare. Sometimes that means returning the children home, sometimes it means arranging permanent foster care, and sometimes it means freeing the children for adoption.

The thrust of my testimony that I was trying to give was that besides any concentration you give to expanding treatment services——

Mr. LEVIN. Which you think is in order?

Mr. BESHAROV. Yes. At the same time look at the child welfare side of this because that's where the decisions are being made day-

to-day. Those are the cases that are giving the caseworkers and the parents, I think, the most troubling concerns.

If you want to help these mothers, make the child welfare system more responsive to their needs, more able to decide where the children should be removed or not, more able to long term plan. That would also help the mothers and children, and that's all I'm trying to say.

Mr LEVIN. You said if you want to help those mothers, make sure the decisions are made because that will also help them. I'm trying to figure out where you're coming from. You're not saying that there aren't many instances where there are inadequate services?

Mr. BESHAROV. That's right.

Mr. LEVIN. So to help mothers in many, many cases we need adequacy of services, which we don't presently have in many cases, right?

Mr. BESHAROV. Yes.

Mr. LEVIN. So then you're saying that there are some cases, many, whatever, where there is adequacy of services, but even with that adequacy the mothers will be incapable in many cases of taking care of the children. You don't say that to diminish the need for more adequate services?

Mr. BESHAROV. No, sir, not at all.

Mr. LEVIN. Let me just ask Dr. Blume, what's the argument here then? As another professional you've heard that formulation, so what's the issue?

Dr. BLUME. Well, as I was listening to this, going up and back, I remembered when I was state commissioner and was sitting in the government person's seat rather than the private provider's seat that I'm in now. When faced with the inadequacy of the treatment that my agency was delivering, I would admit it, but I would also point to all the advances we've made and all the multiplication from where we began. I think that's where we are right now.

Certainly if this hearing were being held 15 years ago we would not be able to point to a treatment service the size of the one Mr. Bliley has mentioned. We had a lot less. We had very few people even interested in talking about this subject. So we have come a long way and we don't want to denigrate the efforts of people who have created that funding for us and that insurance coverage that makes us operate.

Yet, just as I said, let's not congratulate ourselves on a decrease in average alcohol intake when it's rising among young people. I would say let's not congratulate ourselves on the job we've done in making treatment available, because it's not available to everyone who needs it, who would take advantage of it and who would do well in it.

Mr. LEVIN. I think the more the two of you talk, maybe on that point the differences are less than seems apparent at first. Are there differences over the importance of intervention within the family situation?

Dr. BLUME. Not at all.

Mr. LEVIN. You think there are circumstances where there has to be intervention to remove the child from the particular circumstances?

Dr. BLUME. Yes, there are such families. I would further point out that if we ever did the job we ought to be doing of identifying the women now of childbearing age and coming into obstetric practice, who need chemical dependency services, we would absolutely overwhelm the treatment resources out there because so many cases are being missed the way Kathleen's case was missed.

Mr. LEVIN. Just one last quick question, is there any disagreement that the lack of insurance and the inadequacy of the scope of the insurance is one important feature of this problem? Does anybody disagree with that?

Mr. BESHAROV. I would say that for the crack problem I don't think that's as major a question because most of the compulsive crack users that I know are Medicaid eligible.

Dr. BLUME. Come to Long Island and I'll introduce you to many who are not, especially teens who belong to families who have insurance coverage, who are covered for other illness by the parents' insurance, but then when they are in need of these services are bereft.

Mr. BESHAROV. There are always "many." We're talking about whether out of 200,000 compulsive users whether 2 percent or 50 percent are middle class. It is closer to the lower number, not to the higher.

There is one place, sir, where there is a difference, and let me be very blunt about it. If you were to spend—if for some reason the Congress were to authorize and appropriate $2 billion more for drug treatment, which we know is not likely, $2 billion on top of the President's proposal and so forth, I don't think that there would be an appreciable lessening of the child welfare problems faced in this country because current approaches do not have a great deal of success with the heaviest crack users.

Therefore, I think that even if you increased spending, you're still going to have to take action on the child welfare side. My only message here is: Don't focus just on the drug treatment side. There's a lot that needs to be fixed on the child welfare side as well.

Mr. LEVIN. I'd better close. You see, you've stated it, again, in a rather either/or form. You're saying in terms of treatment the picture seems kind of hopeless. So just put your emphasis on the welfare side of it. Maybe that sets the stage for the next panel.

I don't think, Dr. Blume, you agree with that statement, do you?

Dr. BLUME. I don't see it in either/or terms. I would be glad to pick up the challenge of an extra $2 billion. I think if we had residences, as was pointed out, where women coming out of intensive treatment could live with their kids for a few months, six months, eight months, however much they needed to get a good start, I think we would have a lot less need for child placement, but certainly we would still have it.

It would be a good experiment to try.

Mr. MACHTLEY. Thank you, Mr. Chairman.

Before I came to Congress it always amazed me how there seemed to be a problem that everyone could agree was a problem, yet when the federal government got involved, somehow the solution was inappropriate. Whether it was drugs, housing, education, whatever, somehow there is this wide river between the problem

and the solution that we never seem to get across in an adequate way.

So my question really gets to the focus of okay, how do we solve the problem. There is not a single person in this room who has heard this testimony, who has ever dealt with the statistics, who can't say this is a major problem.

It seems to me that if you look at the study that was just done in my state, Rhode Island, that there is a profile for a substance abuser, be it alcohol or drugs. Looking at the testimony is said that cocaine was detected more commonly in women who were other than white, used public insurance, were classified as living in poverty, had one or more children and delivered at the regional perinatal care center.

Should we in the creation of this attempt to solve the problem focus on all women? Should we focus on selected groups of women who are in what we would call a high risk category? Can we afford to put money across the board and then miss the people who really need the services?

Dr. BLUME. Different phases should be targeted differently. Prevention, as I mentioned earlier, has to start with kindergarten and information and prevention have to be spread in all of society. For early intervention, we should target the health care system. We have good technology. In fact, a Dr. Michele G. Cyr did an excellent study at Brown University identifying men and women in internal medicine practice with alcohol problems. Seventeen percent of the women coming into treatment for other illnesses had alcohol problems.

The technology is there to do the identification. Urine testing for drugs is commonly used now. It is pretty accurate and can be used in obstetric practice as well. So the technology to identify the people at most risk is also there. At the prevention level we should target all women. At the treatment level we're going to target those that already have the problem, and we can identify them if we have the systems in which to do that.

Let me just mention something wonderful that the Congress did. I testified a number of years ago, on behalf of the National Council on Alcoholism when there was a debate over what's called the women's set aside, you know what that is, the block grants that go to the states for alcohol and drug programs now require that 10 percent of that money be set aside for new and improved programs for women.

Nobody wanted that. I was the only person at that time who spoke for it, yet we studied the effect of that set aside, and it's been good. I would like to see some teeth put in that set aside to make sure that the states are spending the funds appropriately. Right now it's left to the discretion of the states. I think it could be better used.

There's lots that the Congress has done that's been good, not inappropriate at all. We just need more of it.

Mr. MACHTLEY. Should we have testing for every woman who comes in for prenatal care and then refer them based on that particular test? We have limited resources, how do we spend them, every woman in the high risk population? It would be great if we could focus on every woman.

Dr. BLUME. The test for alcohol problems is as simple as a paper and pencil test. It costs 15 or 20 minutes of time to fill it out in the waiting room and then it costs the training of getting staff to know how to evaluate that test. I'll be glad to submit, (I don't think it's with my testimony now,) a paper and pencil test that has been designed for women that is really easy to use.

That's not a big expense, the expense is training the staff to use them, to be aware, to refer and then to have the treatment on the other end that these women need.

Mr. MACHTLEY. So you think we can do it without much expense, at least as to alcohol, and the question then would become what about drugs?

Dr. BLUME. Right. That could be targeted. Also good history taking would help you target testing in the drug area. What's missing right now is the system to do it, the coordination, the training and, as one of the earlier testifiers said, the will.

Mr. MACHTLEY. Then once we put people into some treatment facility, whatever that might be, going back to the chairman's question again, are we going to measure success by how often they're out of treatment? Is there some incentive, or do we just concede that people will have lapses, whether drugs or alcohol, and we just keep paying? I mean, what should be our standard, how do we deal with encouraging people not to continue?

Dr. BLUME. Well, the programs that do the best, and this has been documented in research, are the programs that have the best follow-up and follow through. If you can afford to have staff that are case managers, that stay in touch with people, that make sure that if they miss a session someone's calling them. Where were you? What happened? In the outpatient phase of treatment, those services are a great luxury in public programs now.

The staff is up to its neck just doing the treatment, and the follow-up is not as careful as it ought to be or could be if there were more resources. So I would say that a relapse is not a total failure if there's follow-up and follow through. The person, as Kathy did, can learn from the relapse and take it from there.

She relapsed and she just stayed out there relapsed. Nobody went looking for her, nobody followed her up. She had to go through a whole new case finding to get into treatment again. We know how to do this. We don't have the resources to do it as much as we would like.

Mr. MACHTLEY. Thank you. I have no further questions.

Chairman MILLER. I want to thank you very much for your testimony.

Let me say that my concern here is, and I'm not sure it's going to be answered this morning, but my concern is our lack of understanding about these women and what works and what doesn't work. That lack of understanding, as well as probably a general lack of understanding about addiction, then drives a model of treatment for families that concerns me a great deal.

Mr. Besharov and I don't have a great debate going here, we have a different view, I think, of what causes what to happen. My concern is that when a woman is pregnant or a woman has children and she can't get a model of treatment that addresses her needs, we then take away her child, whereas we may have been

able to keep them together had there been a treatment model that could address her needs, provide child care—a comprehensive model.

The absence of that then causes a greater intervention by the state into that family. Current law allows us to protect the family, to separate the child, to take him away, reasonable effort or no reasonable effort.

The fact is, that that goes on every year in this country for thousands and thousands of children. It's determined that having made that effort this child should be separated from that parent for health or safety reasons, a whole series. That's current law. My concern is that all too often that is driven by the inadequacy of services for the family in need.

Today we're looking at drug addicted families. We've listened to family court judges in my own state and all across this country who tell us they're simply removing children because of the inadequacy of shelter, not because they weren't loving parents, not because they didn't care for their children, not that they didn't bust their buns to get the kid to school, but the fact was it was unsafe for that child to continue living in that situation for the simple inadequacy of shelter. We've now split up that family.

I have the same concern here. As I talk to probation officers, as I talk to child welfare services, the inadequacy of program causes a sick individual, if you want to use Kathleen's model, an addicted individual, to continue to function in that fashion and, therefore, we now start disassembling the family, very unsuccessful in getting that thing back together once we've started that process.

So my concern is the mismatch between the individual and the services; the adequacy of the services, the effectiveness of the services and the availability of the services are not there so that we start the other effort of taking apart the family.

I think specifically when the select committee sees the number of programs that won't accept pregnant, addicted women, I believe much of it is a liability issue, it's not callousness. Many programs don't accept women with children. Just as many shelters don't accept families, the father has to go here and the mother has to go there and the kids have to go somewhere else. That's wonderful when you're living in downtown Manhattan.

I think that we've got to look at that model. Finally, I'm terribly concerned that the stereotype, which is a black, welfare mother in an urban setting, drives us to believe that well, there's really nothing that is effective here. Yet they probably have the greatest barriers to service, and in all likelihood they're not going to Betty Ford or to the U.S. Naval Center in San Diego. They're going to this place that's kind of trying to maintain people and doesn't have the follow up.

The follow up that you talked about, the contact that you talk about, twice a week, is a real luxury. In the San Francisco Bay area there are only a couple of programs that I can name that have that kind of contact. One program that most of the people on the front line have faith in has 125 contacts after inpatient care ceases. One hundred and twenty-five contacts over the next year.

They consider the program successful if 80 percent of the young people remain clean in a year with that many contacts. There

aren't many programs in the nation that have that. We're real good at keeping you locked up or what have you, but we're not real good at following up.

The other one that concerns me, again, is when we determine success it would seem to me one measure of success in the case of a pregnant woman is if we could provide abstinence for nine months, that that would be some measure of success, certainly for the child. If the notion is that you have to be drug free the rest of your life, then we've got serious problems, because as Kathleen pointed out it's every day, there's no written guarantee you're drug free for the next 50 years and the next 20 minutes.

The people I've talked to who are recovering and sober, I think, make that point. I'm just very concerned and what we're trying to unravel in this hearing is the extent to which the inadequacy of services is driving these other choices. I'm very excited about what Ways and Means—I was over there testifying last week about the merger of some of these services.

There's got to be some standard to measure at what time the state takes away a child. I think reasonable effort—we've got this big project going on in the Bay Area, I don't think anybody has found this to be a barrier to remove a child. Those boxes are being checked without reasonable effort. It's being used—well, that's a debate for Ways and Means, and that's why we have Ways and Means Committee members on here. We will have that debate.

I appreciate very much your testimony here, I just think we've got to know an awful lot more about these women. Because if the focus in the Congress and public policy becomes simply the child, and this isn't to separate them, then we're going to be a little bit like Lucille Ball in the chocolate factory. The children are going to be coming down that conveyor belt faster than we can handle them.

As we've already seen, these children have, in fact, overwhelmed every system they've encountered, these crack babies, and nobody has been able to stand up to them. They're now in the elementary schools and that's not working. I think the challenge is there, but I think in terms of when we have the opportunity, the debates in Ways and Means, the debates in the Commerce Committee, we have a chance now to redesign some of these systems.

We've really got to look to make sure that simple unavailability of services doesn't drive us into a much more expensive and more severe intervention by the state on behalf of families when we have a chance for some successes.

So thank you very, very much. We'll be back to you, obviously, because this is going to be ongoing as these other committees consider legislative suggestions and solutions. Thank you very much.

Kathleen, a special thanks to you. Erin, thank you. You stayed awake through the whole hearing. I consider that a success as a member of Congress. It's better than most of the people up here do from day to day. Thank you very much.

Next we will hear from Iris Smith, who is the director of Prevention and Applied Research for the Laboratory of Human Behavior Genetics at Emory University; Dr. Alan Trachtenberg, who is the medical director, Bay Area Addiction Research and Treatment Pro-

gram in Berkeley, and Dr. Jing Ja Yoon, who is the chief of neonatology from the Bronx Lebanon Hospital in Bronx, New York.

Welcome to the committee, and we will take you in the order in which you are listed, please. Your written statements will be placed in the record to the extent to which you can summarize, we'll appreciate, and the extent to which you want to comment on what you've heard in the previous panel will also be appreciated by the committee.

Ms. Smith.

STATEMENTS OF IRIS E. SMITH, DIRECTOR, PREVENTION AND APPLIED RESEARCH, LABORATORY OF HUMAN AND BEHAVIOR GENETICS, EMORY UNIVERSITY SCHOOL OF MEDICINE; PROJECT DIRECTOR, GEORGIA ADDICTION, PREGNANCY AND PARENTING PROGRAM (GAPP), ATLANTA, GA

Ms. SMITH. Thank you. I'm pleased to have the opportunity to address the committee this morning. As it was stated, I'm currently the director of Prevention and Applied Research at the Laboratory of Human Genetics at Emory University. I am also the project director of the Georgia Addiction, Pregnancy and Parenting Program, which is a model intervention for pregnant and post partum addicts.

I have worked in the field of substance abuse prevention for the past 16 years and I have a commitment to this field as well as to the issue of pregnancy and addiction. I've also been co-investigator on several studies which are ongoing, examining the prenatal effects of drug use during pregnancy.

Based on the testimonies that have been given there is little doubt that this is a very serious problem and that the prevalence of drug-exposed infants is, in fact, increasing. The range of problems can vary from serious developmental effects related to prematurity to milder developmental problems in older kids.

We now recognize that fetal alcohol syndrome is one of the leading causes of birth defects and mental retardation in the United States. The greatest tragedy, is, of course, that it is preventable. When we begin to talk about preventing many of those terrible problems, we're really talking about intervening and doing primary and secondary prevention with women of childbearing ages. I think we often forget that.

We often spend a lot of time and energy talking about what we're going to do about the babies. We do know that there are programs that work, there are data in the field which indicate that. In my written report I talk about a study that we did which was published in 1986, which looked at the effects of a relatively minor educational intervention with a group of alcohol abusing mothers.

What we found was that when you did education during pregnancy, approximately 35 percent of those women who were abusing alcohol at that time would discontinue their use of alcohol. When we looked at the outcomes of their children, we found that there was marked improvement in terms of their growth and in terms of their development later on. We're still following that population of children, they still show improved development.

Another thing that came out of that study was the obvious fact that although 35 percent of those women were able to quit, 65 percent were not. It was out of concern for that 65 percent of the population that we began to develop the Georgia Addiction, Pregnancy and Parenting Project.

One of our objectives is to identify those women who are at risk of continuing to use alcohol or drugs during pregnancy, and also to identify what factors might motivate such women to seek treatment and to look at what kinds of measures of success we can use in terms of evaluating our intervention.

I'd like to respond to some of the things that have been said. I think many of the things that are in my written statement have already been talked about by some of the other presentors here. One of the things I think we really need to emphasize is that early intervention is very important, and that when you do early intervention with a woman of childbearing age, it is also primary prevention, because these women are going to have other children.

So when you intervene in an index pregnancy, you're likely to prevent a future pregnancy from being drug exposed, and I think that's very important. Another early study that we did as part of our project was to really look at women who were going into treatment and compare them to women that we were seeing who were still pregnant and abusing drugs, and to look at differences that might be motivating some women to seek treatment versus those who did not.

One of the things we found was that the women who had gotten into treatment, typically, were women who had hit bottom. They were women who were hurting, they were women who had suffered many kinds of problems in their lives related to drug addiction. The women who were pregnant typically were a little bit younger, a little bit earlier in their addiction process and were not hurting quite as bad.

What that told us was that what was needed was more active case finding and outreach. As Dr. Tuckson pointed out earlier, we have to do case management. We cannot afford to wait until these women walk into a treatment program, and I guess there is still some debate about whether or not such programs are readily available in all areas. In ours they are not available.

We can't wait for the woman to hit bottom, because by that time she's got three or four kids, many of whom many be affected by her drug use during these pregnancies. So it becomes increasingly important that we do education, that we do active case finding, that we do case management with women of childbearing ages, with young women who are in their first pregnancy or their second pregnancy, because, again, we're going to prevent further problems in their children.

Another thing I think that has come out in some of the testimonies that have been made is the critical need for aftercare services. There is a need for a continuum of care, not only detoxification and treatment and rehabilitation, but also aftercare.

I think we tend to think of addiction as being an acute illness that you cure in 28 to 30 days, that someone goes through a program and they should be all right for the rest of thier lives. Well, that's not true. We're talking about a chronic, progressive, debili-

tating illness, which many of these women will struggle with their entire lives. It doesn't go away in 30 days.

As Kathleen pointed out very poignantly in her testimony, for an individual who started using when they were 14 or 15 years old, you cannot expect that in a month they're going to turn around their lives so that they will no longer have to resort to drugs. We have to be able to provide these women with continued support when they return to the community.

One of the things that we're seeing in the population that we work with, and I'm sure everybody in the field is seeing this as well, is that we're getting transgenerational patterns of addiction. Eighty-three percent of the women who are pregnant and using drugs have parents and siblings who also use drugs and alcohol.

A large percentage of those individuals have used drugs and alcohol with other family members. Again, we're talking about something which is so pervasive, and for some so much a critical part of their family upbringing and something that they learned in the home very early, that it's not going to be very easy for them to learn the new kinds of coping skills that they'll need to live a drug free life.

We have to make aftercare services accessible to them to help them deal with deficient coping skills, which will help them deal with an environment that may remain hostile. Many women will have to sever ties with family members, with their male significant others, the husbands, the boyfriends, the fathers of their children who are still actively using and may not support their recovery.

We cannot expect them to return to that kind of an environment and remain drug free, it's simply unrealistic.

I also wanted to respond to something that I heard said, which was that there is a profile or stereotype of women who use drugs during pregnancy. I think we need to be very cautious in promoting stereotypes. We know from national surveys that have been done that drug and alcohol use crosses all socioeconmic and ethnic barriers. It's something that we see everywhere.

One of the things that I think is happening with the issue of pregnancy and drug abuse is that only a few sites are screening for this. Dr. Blume pointed out that often physicians don't ask the question. I think we need to ask the question, where is this data coming from, who are the hospitals who are doing the urine toxicology screens? Are they only the hospitals located in inner city poor communities? Are those the only women who are being identified?

I think that's a question which has not been asked and which certainly needs to be asked at this point in time.

I don't want to go too far over my time, but I think what I'm calling for is a more comprehensive look at what this problem is. When we talk about the solution we talk about it as though there is a magic bullet, as though there is one answer, well there isn't. It's a complex problem, it's multileveled, it affects multisystems, it affects every system in our society.

What we're really talking about are multiple solutions. I agree that there are some changes which need to be made in our child welfare system, we certainly need more specialized treatment services for women, for pregnant women. We need more aftercare and

follow-up services and we need more research, because right now we don't have all the answers as to what is going to be effective with any given population.

Cocaine has provided us with some new information. In some ways it is a different kind of an addiction, we don't have all the answers. Many women that we see are able to stop using drugs on their own. Well, that has happened with other drugs of addiction. There have been some landmark research studies by Velant and Lee Robbins looking at alcoholism and heroin abuse and finding that individuals do quit on their own without treatment. We still don't understand how that happens, we need more research in those areas as well.

So we're talking about something which is very complex, that will require a number of different strategies from a number of different areas. There is no one solution.

Thank you.

[Prepared statement of Iris E. Smith follows:]

Prepared Statement of Iris E. Smith, M.P.H., Director, Prevention and Applied Research, Laboratory of Human and Behavior Genetics, Emory University School of Medicine, Project Director, Georgia Addiction, Pregnancy and Parenting Program (GAPP), Atlanta, GA

I am pleased to have the opportunity to address this committee on the topic of women, addiction and perinatal substance abuse. I am the Director of Prevention and Applied Research at the Laboratory of Human and Behavior Genetics at Emory University School of Medicine. I am also Project Director for the Georgia Addiction, Pregnancy and Parenting Program (GAPP), a model intervention program for pregnant and post partum addicts. I have worked in the field of substance abuse prevention for the past 16 years. I serve on the Board of Directors for the National Association for Children of Alcoholics and have served on the faculty of the Georgia School of Alcohol and Drug Studies. For the past 12 years, I have been a Co-investigator for several research studies on the effects of prenatal exposure to alcohol and cocaine.

There is little question that the increasing prevalence of drug and alcohol use among pregnant women is cause for concern. It has been estimated that 11% of pregnant women use drugs at some time during their

pregnancy. The effects of drug and alcohol use during pregnancy may range from miscarriage to developmental delays and behavioral problems in exposed children. Fetal Alcohol Syndrome, which results from heavy alcohol use during pregnancy, is now recognized as one of the leading causes of birth defects and mental retardation in the United States. The social costs of providing remedial services, foster care placement and medical care for these children are excessive. The greatest tragedy is that these problems are 100% preventable.

Recently most of the attention has been directed toward intervening with prenatally exposed children. However, when we speak about the prevention of perinatal addiction, we are essentially talking about early intervention with women of childbearing ages who are abusing or at risk of abusing drugs and alcohol. Prevention is always proactive. Thus, we must begin to develop and implement strategies for working with the woman at risk before she has given birth to an affected child. There are different levels of prevention. Primary prevention involves intervening with women of childbearing ages who are not pregnant. Such strategies may take the form of education. Secondary prevention, or early intervention, involves intervening with an identified population at risk. In 1986, we published the results of a study on the effectiveness of an educational intervention with pregnant alcohol abusing mothers. We found that, when presented with information on the potential harm of alcohol use during pregnancy, 15% of a sample of alcohol using pregnant women would discontinue their alcohol use out of concern for their unborn child. When we evaluated pregnancy outcomes in that study, we found that the infants of women who had stopped drinking had improved intrauterine growth and behavioral development when compared to the infants of mothers who drank throughout pregnancy. This

occurred even if the mother had been drinking into her second trimester (see Appendix A).

These findings provide strong evidence that educational interventions will work for some of the women at risk. Other studies have also found that pregnancy often provides a "theraputic window" for intervention with the pregnant addict and many women will abstain from alcohol and drug use during pregnancy.

It was evident from the study I have described to you, that the 65% of these women who had been unable to discontinue their use of alcohol constituted a high risk group. When we examined the differences between the stopped drinkers and the continuous drinkers we found that the women in this group were more likely to have experienced social or medical problems related to their drinking. They more often came from alcoholic families and had alcoholic siblings and typically began drinking at an earlier age than the group of women who had been able to stop. All of these things seemed to indicate that this group of women might benefit from a more intensive theraputic intervention. The results of this study formed the rationale for development of the Georgia Addiction, Pregnancy and Parenting Program (see Appendix B).

One of the primary objectives of the GAPP program is to identify factors which motivate women to seek treatment for their alcohol or drug problems as well as those factors which constitute barriers to treatment. Our experience has indicated that one of the greatest barriers to treatment is, quite simply, the lack of it. Few programs provide services specifically for women and even fewer provide specialized services for pregnant women and new mothers. Many residential treatment facilities do not admit pregnant women as a matter of policy. For example, in the metro Atlanta area only 2 programs offer specialized programs for women, the Metro Atlanta Recovery Residences and the Fulton County Alcohol and Drug Treatment Center. With the exception of GAPP, there are no programs

specifically targetted for the pregnant addict. Other barriers to treatment include the lack of childcare provisions, inadequate insurance coverage, and lack of transportation to and from treatment facilities.

There is now considerable data in the field to suggest that programs which provide services for the pregnant addict can reduce the incidence of poor pregnancy outcomes in this group. For example, The Family Center at Thomas Jefferson University Hospital, which provides comprehensive medical and substance abuse services to pregnant women, has successfully reduced the incidence of low birthweight births from nearly 50% to 18%. Other prototype programs such as the Pregnant and Addicted Mothers Program (PAAM) have demonstrated that parenting education, combined with comprehensive substance abuse treatment can positively impact child outcome. In a program for pregnant alcohol abusers at Boston City Hospital, Dr. Henry Rosett demonstrated that 66% of a group of alcoholic pregnant women who participated in the program either reduced or discontinued their use of alcohol and significantly improved the birth outcomes of their children.

In developing substance abuse treatment programs we often fall victim to the "myth" of addiction as cause. There is a tendency to think of addiction as an acute illness, which one can treat (and cure)in 28-30 days. We assume that once we have "treated" the addict, all of her other life difficulties will disappear. This is not the case. Drug addiction is a chronic, progressive and debilitating disease. Moreover, it is multi-determined. There are multiple paths to addiction. Risk factors include psychological, biological as well as environmental factors. Once the addict has come to terms with her addiction, she must come to terms with her life. Studies of addicted women have found that compared to

non-addicts, they are more likely to have been victims of physical and/or sexual abuse (some studies have found the prevalence to be nearly 5 times higher), to be single mothers and to have a higher incidence of medical problems. Often they lack marketable job skills and employment experience. Many come from alcoholic or substance abusing homes. In our study, we are beginning to see transgenerational patterns of addiction. 83% of our clients report that other members of their families use alcohol or drugs. 47% have used alcohol or drugs with their mothers and 23% have used with their fathers. Many of these women will return to drug infested environments where there is little support for their recovery.

For any addict, recovery from addiction is a life long process. As with other chronic illnesses, there is a risk of relapse. Relapse is not failure. Occasional relapses during the early stages of recovery are not uncommon. Continued support and reinforcement for a drug free lifestyle can prevent a single relapse from triggering an extended period of use. Twelve step programs such as Alcoholics Anonymous, Cocaine Anonymous, and Narcotics Anonymous have been shown to be effective in promoting continued abstinence among recovering addicts. Traditionally, such programs have provided aftercare support through a network of self-help groups run by recovering addicts. However, these groups are not equally accessible in all communities. For example, a recent survey in metro-Atlanta indicated that of 900 12 step programs, only 6 % were located in predominantly black, low income communities. There is a critical need for a complete continuum of care which includes not only detoxifcation and treatment but also aftercare services to provide continued support to recovering women after they return to the community. Such programs must be accessible both geographically and economically. They should include the following

~~Page 5~~

31-228 0 - 90 - 4

components at a minimum: vocational training; job placement, child care; relapse prevention counseling; and parenting education. Many women who are commited to their recovery have been forced to sever ties with drug using spcuses, boyfriends or family members, upon whom they have been economically and emotionally dependent. Complete and successful recovery means that these women must acquire the skills to become independent economically and emotionally.

The prevention of alcohol and drug related birth defects is a national priority. Prevention, by definition, means that we must be proactive in intervening in the process of addiction in women of childbearing ages. This is a multi-dimensional problem which will require many different strategies at the individual, family and societal level. While there is some truth to all sterotypes, not all women who use drugs during pregnancy lack of concern for their child. Rehabilitation services for pregnant women are often not available, and as a result, many women who want drug treatment cannot get it. When such services are available, women are able to recover from their addiction. I have appendiced to this report several case summaries of women we have seen. These cases are typical of those who are seeking help for their addiction. Some have been successful in conquering their addiction, others have been blocked by the failure of a non-respsonsive system which created barriers to help.

In conclusion, while it is imperative that we take appropriate measures to safeguard the welfare of our next generation, it is equally important to ensure that those women who are motivated to seek help for their addiction are able to find it. The creation of punitive consequences for drug use during pregnancy, must be balanced with compassion and understanding for the drug addicted mother. Treatment

approaches must be comprehensive with a continuum of services that includes aftercare. Substance abuse is often only a symptom, we must design programs to treat the whole person and not just the addiction.

References

Finnegan, L.P. (1990). Testimony to Subcommittee on Children, Family, Drugs and Alcoholism, United States Senate. February 5, 1990

Lief, N. (1981). Parenting and child services for drug dependent women, in Treatment Services for Drug Dependent Women, 1, pp. 455-498.

Rosett, H.L.; Weiner, L. (1984). Alcohol and the Fetus: A Clinical Perspective. New York, Oxford Press.

Client: #1
Pregnant, 29 year old, divorced, black female.
Has an 11yr. old son who lives with the client's mother.

Education: 11th grade
8 mon. Cosmotoloty school

Employment: worked 2yr. as a cashier

Summary: Client self referred to GAPPP at 6mon. of pregnancy. She reported as a 1-2/mon. Cocaine user and an occassional cannabis user. She states that she began snorting cocaine at age 25 and then switched to smoking a pipe. GAPPP assisted her entering Clifton Springs' outpatient treatment program. After one week she discontinued treatment. She reportedly relapsed and went home to live with her mother outside of the Atlanta area. She reported that she began attending AA groups at this time and began her abstinence. In Dec. of 1989, after the delivery of her second son on 9-26-89, she returned to Atlanta. She is raising her new son and attending Clifton Springs' evening groups. She has reportedly been abstinent for 12 months.

Family: One of 6 children. Reports no family substance abusers other than her brother who drinks alcohol.

Client: #2
Pregnant, 33 yr. old, black, single, female.
Has a 3 yr. old daughter who lives with her and a 17 yr. old daughter who lives with a relative.

Education: 2 years of college, Nursing Aid skills.

Employment: Worked in Food Services for 3 years.

Summary: Client reported that she began using alcohol at age 12. Her primary drug of use is cocaine. She reportedly has used alcohol, cocaine, amphetamines, and cannabis on a weekly basis over the past 10 years. Client entered FATC inpatient treatment program at the time of her referral. She delivered a baby girl on 6-15-89 while still in treatment. She gave the child up for adoption and continued her treatment. Upon completing her treatment she was accepted into Village Atlanta. While there she obtained a job (factory production) and attended AA and NA groups. She is reportedly still abstinent and working, and currently living in a local housing complex.

Family: Client reports that her mother, father, and grandfather were alcoholic, and her siblings were alcohol and drug abusers.

Client: #3
Pregnant, 36 yr. old, black female.
No other children.

Education: 12th grade, 12 month data entry certification.

Employment: 4 mon. Soldier Technician

Summary: Client reported that she began using alcohol at age 21 and reports to monthly use of cocaine and cannabis for the past year. She has never been in treatment but has attended GAPPP groups at FATC since December. She states that she has been abstinent for 4 months. On 4-6-90 she delivered a healthy baby boy. She is currently living with her boyfriend and plans to return to her soldier technician position as soon as possible.

Family: She reported that her twin brother uses cocaine, but no other family members use drugs or alcohol.

The Georgia Addiction, Pregnancy and Parenting Project

Georgia Mental Health Institute ✦ 1256 Briarcliff Road, N.E.
Atlanta, Georgia 30306
Telephone (404) 894-8288

WHAT IS THE GEORGIA ADDICTION, PREGNANCY AND PARENTING (GAPP) PROJECT?

The Georgia Addiction, Pregnancy and Parenting (GAPP) Project, is a special intervention program for pregnant women who are abusing drugs and/or women who have recently given birth to a child who was prenatally exposed to drugs. The GAPP Project is located at Georgia Mental Health Institute, 1256 Briarcliff Rd., NE, Atlanta, GA. It is jointly sponsored by the Ga. Department of Human Resources, Alcohol & Drug Section and Emory University School of Medicine.

The Origins of the GAPP Project

The GAPP Project began in 1980 as a research program to study the effects of alcohol use during pregnancy on the growth and development of the child. The original research project included the identification and followup of women who were at risk for giving birth to alcohol affected children as well as the evaluation and followup of such children.

The initial research concluded by this program indicated that prenatal alcohol exposure can lead to a continuum of poor developmental outcomes in exposed children ranging from full Fetal Alcohol Syndrome (FAS) (which includes abnormal facial appearance, retarded growth and mental development) to learning and behavioral problems in children who otherwise appear to be normal (Smith, 1979; Coles et al., in press).

Women who participated in the study were given information on the harmful effects of alcohol use during pregnancy. Those who had evidence of chronic alcohol and/or drug problems were advised to seek additional counseling. As a result of the information and counseling provided, thirty-five percent (35%) of those women who were using alcohol at the time of the interview discontinued their use of alcohol before the third trimester (Smith, et al., 1987). The results of the neurological and behavioral assessments conducted on the newborn infants indicated that the children of women who stopped drinking had a better developmental outcome than those of women who continued to drink during pregnancy (Coles et al, 1984; Coles et al., 1985; Coles et a., 1987; Coles et al., in press; Smith et al., 1986).

Our findings with regard to the consequences of prenatal alcohol exposure raised important questions about the developmental effects of other drugs of abuse. With the exception of research on heroin and methadone this remains a largely unexplored area. In addition, our finding that many of the developmental effects resulting from prenatal alcohol exposure could be prevented with intervention during pregnancy, highlighted the importance of early intervention with pregnant women who are abusing alcohol and/or other drugs.

In March, 1987, the legislature of the state of Georgia funded the GAPP Project to develop a model intervention program for pregnant women in the greater Atlanta metro area who are using drugs or alcohol. In addition, the availability of federal grants funds has enabled us to expand our existing research program to include the study of the effects of prenatal exposure to cocaine and other drugs.

WHAT SERVICES ARE AVAILABLE THROUGH THE GAPP PROJECT?

Information and Referral Service.

GAPP is currently compiling data on all programs serving Dekalb/Fulton County residents which provide services to pregnant women and young children. We also maintain a large database of information on the known effects of prenatal drug exposure. GAPP is a multidiciplinary program and our staff includes individuals with expertise in the following areas: developmental and clinical psychology, social work, addictions, public health and pediatric medicine.

Community Outreach and Education.

GAPP staff are trained to provide educational consultation to lay and professional groups on the effects of prenatal exposure to alcohol and/or other drugs, identification and screening of pregnant women at risk for drug abuse, and the epidemiology and treatment of drug abuse among women.

Support Groups for Pregnant Women Who are Abusing Alcohol and/or Other Drugs.

As part of our intervention program, the GAPP Project conducts weekly support groups for pregnant women who have been using drugs during pregnancy in order to help them achieve and maintain abstinence. Groups are open to all greater Atlanta metro area residents free of charge.

Parenting Education.

In addition to the pregnancy support groups, GAPP also conducts weekly parenting groups with mothers who have recently given birth to a child who was prenatally exposed to alcohol and/or drugs. The focus of the parenting classes is to provide support and reassurance as well as to provide education and training in effective parenting skills and normal child development. Parenting groups are open to women in metro Atlanta county who have given birth to a child within the last 30 days who was prenatally exposed to alcohol and/or drugs.

Aftercare and Support Program for Newly Recovering Pregnant and Post-partum Addicts.

The Aftercare Program is intended as an adjunct to services provided by the alcohol and drug abuse treatment programs with a specific emphasis on topics related to parenting, prevention of relapse, coping, and re-entry into the community. Through collaborative agreements with the Alcohol Treatment Center in Fulton County, Fox Recovery Center in Dekalb County, Atlanta West Treatment Center, Village Atlanta and the Save the Children Foundation we propose to develop, implement and evaluate a comprehensive Aftercare Program for newly recovering pregnant and post-partum addicted women.

The goals of the Aftercare Program are to: (1) reinforce continued abstinence following completion of drug treatment; (2) promote the development of healthy, adaptive coping skills; (3) provide training in interpersonal, employment and parenting skills. (4) to provide childcare to recovering mothers in order that they may participate in drug treatment and/or aftercare services.

Developmental Evaluations of Drug-Exposed Children.

The GAPP Project staff includes two consulting developmental psychologists with expertise in the testing and evaluation of children prenatally exposed to alcohol and other drugs. Developmental evaluations of all children whose mothers participate in the program are provided free of charge. Evaluations of children not being followed by the GAPP Project are available on a limited basis.

Ongoing Research on the Effects of Prenatal Drug Exposure.

In addition to above activities, the GAPP Project is continuing its ongoing research on the effects of prenatal exposure to alcohol, cocaine and other drugs of abuse. Our research program includes the identification and screening of women at risk for continued abuse of alcohol and/or other drugs during pregnancy, neurobehavioral and medical evaluations of infants prenatally exposed to drugs of abuse and laboratory studies of cytogenetic and immunological changes resulting from drug use.

References

Smith, I.E. (1979). Fetal alcohol syndrome: A review. J. Med. Assoc. Ga., 68, 799.

Coles, C.C.; Smith, I.E.; Fernhoff, P.M.; Falek, A. (1984). Neonatal ethanol withdrawal: Characteristics in clinically normal, nondysmorphic neonates. J. Pediatr., 105, 445.

Coles, C.D.; Smith, I.E.; Fernhoff, P.M.; Falek, A. (1985). Neonatal neurobehavioral characteristics as correlates of maternal alcohol use during gestation. Alcoholism: Clin. and Exp. Res., 9, 454.

Smith, I.E.; Coles, C.D.; Lancaster, J.S.; Fernhoff, P.M.; Falek, A. (1986). The effectof volume and duration of prenatal ethanol exposure on neonatal physical and behavioral development. Neurobehav. Toxicol. and Teratol., 8, 375.

Coles, C.D.; Smith, I.E.; Lancaster, J.S.; Falek, A. (1987). Persistence over the first month of neurobehavioral differences in infants exposed to alcohol prenatally. Infant Behavior and Development, 10, 23.

Smith, I.E.; Lancaster, J.S.; Moss-Wells, S.; Coles, C.D.; Falek, A. (1987). Identifying high-risk pregnant drinkers: Biological and behavioral correlates of continuous heavy drinking during pregnancy. J. Studies on Alcohol, 48, 304.

Coles, C.D.; Smith, I.E.; Falek, A. (in press). Prenatal alcohol exposure and infant behavior: Immediate effects and implications for later development. Advances in Alcohol and Substance Abuse.

[The article entitled: "Identifying High-Risk Pregnant Drinkers: Biological and Behavioral Correlates of Continuous Heavy Drinking during Pregnancy, from Journal of Studies on Alcohol, Vol. 48, No. 4, pp. 304-309, July 1987, is retained in committee files.]

Chairman MILLER. Thanks for that uplifting testimony.
Dr. Trachtenberg.

STATEMENT OF ALAN I. TRACHTENBERG, M.D., M.P.H., MEDICAL DIRECTOR, BAY AREA ADDICTION RESEARCH AND TREATMENT (BAART), BERKELEY, CA

Dr. TRACHTENBERG. I want to echo some of the things that have been said. Those of us in the maternal and child health field are very grateful for the work of this committee in general for having done so much to advance the health of children and families in this country. It's wonderful that you're really trying to go beyond the stereotypes of addicted pregnant women and kids today.

My name is Alan Trachtenberg. I'm the medical director of Bay Area Addiction Research and Treatment. We are a private nonprofit corporation that contracts with counties and also has private fee slots. We treat over 1,200 patients at any one time between San Francisco and Contra Costa County, not Berkeley, although I do live there and it's a very interesting place to live.

Chairman MILLER. It has been.

Dr. TRACHTENBERG. I'm also the medical director for the part of BAART which we call FACET, the Family Addiction Center for Education and Treatment. FACET is one of the few drops of water sitting on the bottom of a, for the most part, dry glass. We are eagerly awaiting the day when the glass is half full.

I would like to tell you a story that came from one of the other parts of the glass that is unfortunately dry. Just north of where you and I are from, Mr. Chairman, Butte County, there is a woman that the National Center for Youth Law calls Michelle who was an AFDC recipient, the mom of a seven year old, a heroin addict who became pregnant in 1988.

She learned at that time that the indicated treatment for an opiate addict who became pregnant was methadone maintenance through the time of delivery. There's a lot of medical consensus and good medical data that shows that it is much better for the fetus and the mother to maintain her on methadone during the course of the pregnancy. Unfortunately, there is no methadone treatment available in Butte County.

The policy there seems to be that they don't want drug addicts there, so they don't have treatment, or they didn't in 1988, and still don't have treatment. Addicts there have to go 140 miles roundtrip to get treatment. Michelle had to drive to Sacramento, which was 70 miles away each day, to get her methadone. She did get into prenatal care.

She was able to pay the $200 a month fee from her AFDC. Things were going well, her prenatal care was going well until her car broke down. She continued to get to the clinic as often as she could. She begged rides, borrowed them, paid people to take her there, hitch-hiked sometimes, which got progressively more difficult as her pregnancy went on. This added expense, though, took its toll on her meager income and eventually she got in arrears in her payments at the clinic and, having difficulty getting there, and not being able to keep up in her payments, she was not able to continue going to the clinic.

In her eighth month she went back to using heroin, which is a decision that I really can't criticize her too much for, because we do know that intrauterine withdrawal is very dangerous for the fetus. She did what in her situation might well have been in the best interest of her fetus.

A few weeks before she did go in to labor, the Butte County district attorney had announced a policy of prosecution for any woman who delivered a baby with drugs on board. Despite this, when she did go in to deliver Michelle told the hospital staff about her medical condition, that she had been using drugs so that they could give the best possible care to her child.

The next day she was visited by the Butte County district attorney and the child protective services who did take her baby. The district attorney was planning to prosecute and only dropped the prosecution under the pressure of a lot of adverse publicity about the case.

Today the child is still in the custody of the Butte County Child Protective Services. I don't know what has happened to this child, but we do know in California the usual child removed from the family is bounced around to two or three different foster care placements. One thing we do have to keep in mind is it doesn't solve the problem to take a child out of the family. What's going to happen next? It's not a solution, it's just, perhaps, a different kind of problem.

Today there is still no methadone treatment for any opiate addicts, not even for pregnant women, other than to send them 70 miles each way to Sacramento to get their methadone, or a little further to Davis or Pittsburgh is another site that we have. We do have women who come that far to our clinics in Pittsburgh and Richmond from north of us in California.

I think that story is the most important thing I wanted to tell the committee, the rest of my remarks are in the written testimony. I did want to point out, however, that things are bad and, if anything, getting a little worse for poor women and addicted women. Currently Medi-Cal does not reimburse for the treatment of cocaine addiction at all.

It's been proposed in next year's Medi-Cal budget that treatment for heroin detoxification will no longer be reimbursed. This past year, as you know, two thirds of Office of Family Planning's budget in the state of California was cut and the Office of Family Planning-funded family planning clinics are the only source of gynecologic care for many poor women, both addicts and non-addicts. That funding was only put back after a very hard-fought, rancorous political battle. In fact, clinics did close, women were not able to get gynecologic care to prevent them from getting pregnant, to prevent them from getting sexually transmitted diseases like AIDS and cancer of the uterine cervix.

In Contra Costa County about 10 percent of my patients have HIV infection, and most of them have—in Contra Costa County—some access to fairly good HIV related care from the county. In San Francisco the system is a little bit more overburdened, we do have more difficulty in getting care for the seven percent of our patients there who have HIV infection.

There is an epidemic of tuberculosis in Contra Costa County among young adult crack smokers. Crack is smoked in small, enclosed rooms, the ventilation is purposely kept poor to prevent detection. It's just a tailor-made environment for transmission of the tubercule baccillus. It should not be surprising that there is such an epidemic.

Luckily some of these crack smokers are, in addiction, heroin addicts. I say luckily because then they may come into one of our clinics, and we skin test everyone for TB and are working very closely with the county health departments to give appropriate treatment to people with TB infection before they get active disease and spread it further.

The only reason the pregnant women and the TB infected patients, et cetera, come to our clinic is because we have a modality of treatment which is acceptable and desirable to many of the addicts, that is, we have methadone. We're the only source of medical and public health services for many of the patients. They don't come to us for that, though, they come to us because we have something that they want.

That has to be seen as a very important public health intervention to bring addicted women into treatment, to help us get them into prenatal care. The resources that are needed by these women—are far more than just the medical care, the very limited medical care we're able to give them. They need transportation.

You know, Michelle's story is very common. I have lots of patients who are, unfortunately, no longer patients because they weren't able to keep coming into the clinic every day as they're required to by regulation, to get their methadone. Transportation is a horrendous problem. If there were one thing that I could ask this committee to recommend, it would be travel vouchers or some access to transportation for all pregnant women, especially pregnant addicts, along with the needed access to medical care.

Thanks very much.

[Prepared statement of Alan I. Trachtenberg follows:]

PREPARED STATEMENT OF ALAN I. TRACHTENBERG, M.D., M.P.H., MEDICAL DIRECTOR, BAY AREA ADDITION RESEARCH AND TREATMENT (BAART) AND THE FAMILY ADDICTION CENTER FOR EDUCATION AND TREATMENT (FACET), BERKELEY, CA

Mister Chairman, honorable members of the Select Committee, thank you for inviting me to speak with you today as you reach beyond the deceptive and counter-productive stereotypes of addicted women and their children. This committee has accomplished much for American children, youth and families, but there is much that still needs to be done for the children and families victimized by the disease of drug addiction.

My name is Alan Trachtenberg and I am the medical director of Bay Area Addiction Research and Treatment. BAART is an agency with over 1,200 patients in the San Francisco Bay area in treatment at this time. All of them are opiate addicted and mostly injection drug users. I supervise both methadone detoxification and methadone maintenance services, including FACET, which is the Family Addiction Center for Education and Treatment. We are the only program providing outpatient methadone services to pregnant women in San Francisco and Contra Costa County.

>ONE DRUG USING MOTHER'S STORY

To start with, I would like to tell you a story about a pregnant woman who did not have access to a program like ours. The National Center for Youth Law calls her Michelle (not her real name) (National Center for Youth Law, 1990). Michelle was an AFDC recipient with a seven year old child and a heroin habit when she discovered she was pregnant in 1988. Determined to minimize the harm to her fetus, she contacted every local agency she could for help in obtaining treatment for her drug addiction. She even contacted local media in the hope that she might find a journalist who had information about treatment programs.

In all of Butte County, California, where Michelle lived, there was not a single treatment program available to her. There are no methadone programs in Butte County, where the feeling is that drug addicts are not wanted and social rather than medical approaches are more appropriate. The medical literature is quite clear, however, that once a heroin addict becomes pregnant, the safest therapy for the fetus and the mother is methadone maintenance (NIDA, 1979). Michelle learned that the nearest methadone clinic was in Sacramento, seventy miles away.

The Sacramento clinic had a two-year waiting list, but because Michelle was both pregnant and persistent she was admitted to the program. She paid the $200.00 monthly fee from her AFDC grant and drove 140 miles round trip to Sacramento. Regulations required her to attend clinic every day to receive her dose of methadone.

Michelle obtained prenatal care and was doing well in treatment until her car broke down. Still, she managed to get to Sacramento nearly every day, begging friends or family for rides, or buying them, and on occasion even hitchhiking. These added expenses from her meager income caused her to fall behind in her payments to the clinic.

Eight and one half months pregnant, with no dependable way to get to the clinic and no way to pay its fee, Michelle gave up on the Sacramento program. A student public health nurse who was seeing Michelle as part of her prenatal care also tried to help her find treatment closer to home. They both came up empty-handed. Finally, unable to obtain treatment, Michelle returned to heroin use, a decision that was not entirely inappropriate, since sudden withdrawal could have been deadly to her fetus.

Shortly before Michelle gave birth, the Butte County District Attorney had announced a policy of criminal prosecution for any woman who gave birth to a baby that tested positive for drugs. Such tests are not routine for a full term baby whose mother has been in prenatal care, and it is quite possible that a mother could avoid such testing by hiding information from the hospital staff. However, when her baby was born, Michelle immediately told hospital staff about her drug use, so they could provide appropriate treatment to her baby. The next day, Michelle was visited by representatives of the DA's office and Child Protective Services, who took the baby away from her. Despite being told of Michelle's valiant efforts to obtain treatment, the DA announced plans to prosecute her for illicit use of a controlled substance. Only after a great deal of adverse publicity did he drop this criminal prosecution.

Today, Michelle's Baby is still in the custody of Butte County Child Protective Services. Michelle's attorney, Lucy Guacinella, tells me that in 1990 there are still no methadone services for pregnant addicts in Butte County. In fact, heroin addicts still have to travel at least 140 miles each day for any kind of drug treatment at all, except some inpatient care available for alcoholics. This legal services attorney has spoken with several pregnant women who use drugs and plan to avoid prenatal care for fear of prosecution. She even knows of one woman who went without any prenatal care and delivered at home due to this fear.

>THREE ESSENTIAL POINTS

I would like to make three essential points today.

The first is that pregnant and non-pregnant addicted women desperately need increased access to appropriate medical and supportive services. They can ill afford increased barriers like the fear of prosecution or the disdainful attitude of many professionals. It would be a far better use of scarce funds to allocate them to our starved treatment infrastructure than to the already overburdened judicial system.

The second point is that addiction, along with many other diseases, is a public health consequence of oppression and poverty. I initially realized this while I was serving in the United States Public Health Service on the Pine Ridge Indian Reservation. This was the first time I came face-to-face with a people who had been nearly decimated by long term social neglect

and the consequent problems of intergenerational poverty, much as the population of our inner cities. The current epidemic of drug addiction is growing up like weeds on a neglected lawn. The real solution is not toxic herbicides, nor is it cost effective to pull each weed out by the roots. The real solution is to seed and water the lawn.

The third point addresses our hysterical and judgmental attitudes about drug addiction, which is a chronic relapsing disease that is seldom cured, but for which some effective treatments do exist. As a society we are currently focusing an inordinate amount of attention on particular illicit drugs and virtually ignoring other much more important determinants of the health of our women and children, such as cigarette smoking and the lack of universal access to medical care.

>ACCESS AND BARRIERS TO CARE

To return to my first point, I would plead to this committee to stop the obstetrical wards of this country from being turned into obstetrical jails. My patients are surprisingly good at staying away from jail situations. Any measure that increases the mean birth-weight will decrease the neonatal morbidity and mortality. A policy that drives any population away from prenatal care decreases that population's birthweight and increases the amount of disability and death which will occur in the newborns of that population. Addiction is defined as a disease of compulsive substance abuse which the addict continues despite adverse consequences. Fear of prosecution will not scare pregnant addicts out of using drugs, it will just scare them away from any contact with a system that they must access to get the prenatal care and drug treatment that they so desperately need. Even if a woman continues to use drugs during pregnancy, proper prenatal care will still improve the birth outcome in comparison to a drug using woman who obtains no prenatal care. (MacGregor et al, 1989).

The physician who cares for a pregnant addict has several patients. We care for the woman, we care for the unborn, we care for the already born (her other children) and we care for the father, if he is present. These are fragile families that, if given proper support, could in many cases be better environments for children than our chaotic foster care system (Dixon, 1989). Make no mistake, there are certainly cases in which children do need to be removed from the biological family. But the judicial approach should be a last resort, only after treatment has been available and failed or not been utilized despite its geographic and cultural accessibility.

>THE ROOTS AND BITTER FRUITS OF ADDICTION

My second point addresses drug addiction as a public health consequence of oppression and poverty. Most of my female patients have been either sexually or physically abused as children or severely assaulted as adults (Regan, Erlich &

Finnegan, 1987). Many are forced by the economic circumstances of their lives to exchange sexual behaviors for the means they depend on to survive.

Most influential people in our society seem to have little interest in an addicted woman until she becomes pregnant, often unintentionally. Then, if she doesn't happen to live in one of the few states whose Medicaid programs still cover abortion services, and if she cannot accumulate enough money in a limited time, she may be unable to terminate her pregnancy despite her wish to do so. Whether or not the pregnancy was desired, many programs will not admit or continue to treat pregnant clients for various reasons. These may include the additional and often unreimbursed cost of the extra services and monitoring required during pregnancy. After delivery, society again loses interest in the woman, except in her role as a potentially unfit mother.

If we want to create good environments for the children of addicted mothers, we must consider making the resources available for safe and healthy homes. Then none of my patients would ever again have to resort to post-partum prostitution to avoid living on the street. Pregnancy and childbirth have been shown to be risk factors for homelessness (Weitzman, 1989). In a caring society this should not be the case.

But why are we focusing today on the pregnant addict? Does anyone care about the addict before she conceives? Who cares enough about her to fund the non-threatening contraceptive services she may need to keep from getting pregnant and to keep from getting sexually transmitted diseases like AIDS or cancer of the cervix? Last year, two thirds of the funding for California's Office of Family Planning were cut. Except for a last minute and hard fought reversal, this would have resulted in the closure of many clinics which were the only source of gynecologic care for thousands of poor women, non-addicts as well as addicts.

What about the treatment women need for their drug addictions? In our program in San Francisco almost half of our clients are female. Nationally, women are under-represented in drug programs with only one third of addicts in treatment being female. Why has the Medi-Cal budget for the next fiscal year completely eliminated reimbursement for all heroin detoxification services? This is especially concerning in light of regulations which require that every addict have at least one unsuccessful detoxification attempt before being eligible for methadone maintenance. Expanded access to drug treatment has been recommended by every major task force or commission to address the AIDS epidemic. Seven percent of my patients in San Francisco and ten percent of my patients in Contra Costa County are infected with HIV, the AIDS virus. Many of them had their infections first diagnosed by our testing programs. Many of our pregnant patients have first been admitted as detoxification clients. Their pregnancies were diagnosed by us, and they were started early into prenatal care due only to the concerted

efforts and caring attitude of the methadone maintenance staff.

Although many of the pregnancies we see are unintentional, some are very much desired by the patients. We must recognize that reproduction may be the only source of self-esteem available to these marginalized women who are given the clear message from our society that they are not worthy of concern or protection.

In an effort to provide what seemed to be a solution to the last epidemic of heroin addiction, many state legislatures made the non-medical possession of injection equipment ("works") illegal. The consequence of this legislation, now as apparent to many addicts as it is to the public health community, was to greatly increase the transmission of bloodborne infections such as hepatitis B and HIV from addict to addict. From addicts these infections spread to their sex partners and children.

Legislators must recognize that many of the diseases associated with drug addiction are not the result of the drugs themselves but rather the social environment in which the drugs are ingested. A good example of this is the epidemic of tuberculosis now being seen in the young adult crack smokers of Contra Costa County. People smoke crack in crowded rooms with ventilation purposely minimized to lessen their risk of detection. They inhale hot gases and cough in close quarters, creating an environment practically tailor-made for optimal transmission of the tubercle bacillus. One or two people in this environment may have had quiescent Tb infections for many years, until their more recent and probably unsuspected HIV infections broke down their immunity. Pulmonary tuberculosis will likely go undetected for some time, since addicts are even more likely than non-addicts to ignore symptoms such as cough and weight loss. Meanwhile they spread their Tb infection by the respiratory route. Luckily some of these crack addicts will also be addicted to heroin, and some of them will find their way into one of our clinics where we perform skin testing for Tb infection on all of our patients. We work closely with the county health department to eradicate this preventable disease.

We are also the first contact many of our patients have with any HIV counseling or testing services. Additionally, we are able to get the majority of our pregnant addicts into prenatal care, despite the scarcity of obstetricians willing to see our patients. We would not be able to conduct any of these vital public health interventions with our clients if they did not come into our clinics. We are the only source of medical care that many of them ever are willing or able to utilize, but they do not come to us primarily for medical care. They come because we have methadone, which is to them the most acceptable and immediately useful treatment for their chief complaint: opiate addiction. I regret that we do not yet have a similarly acceptable and useful pharmacologic treatment for cocaine addiction. I am even more regretful that not all methadone clinics are able to offer the primary care and public health services that we offer at BAART.

>A PUBLIC HEALTH PERSPECTIVE BEYOND THE STEREOTYPES

My third point has to do with the hysteria with which America is now addressing the problem of addiction to illicit drugs. The news media barrage us with story after story of the alternating waves of stimulant and opiate addiction which have swept this country since the early part of this century. But why are we focusing only on illicit drugs? Legal drugs like tobacco are causing vastly more disability and death to America's newborns than heroin and cocaine. Should we imprison pregnant smokers? Should we continue to give federal subsidies to a tobacco industry that addicts thousands of future mothers every year with cynical advertising campaigns to convince teenage girls they will be sexier and have more fun if they smoke this or that brand of cigarette? At least five to ten percent of all stillbirths and neonatal deaths are attributable to smoking in pregnancy (De Haas, 1975; Meyer et al, 1976). Furthermore, pregnancies of smoking mothers show about the same increased risk of infant wastage as pregnancies at high altitudes (De Haas, 1975). Would this committee be prepared to follow a proposed policy for jailing pregnant addicts (for the protection of the unborn) to its logical conclusion by recommending that all pregnant women who stubbornly remain in high altitude domiciles should be forcibly detained in sea-level, smoke-free, prenatal camps? I do not advocate such action. However, across the U.S. at least 18% of all low birth weight is caused by smoking (Simpson & Armand-Smith, 1986), while even in Alameda County, California, which contains inner city Oakland neighborhoods decimated by crack, only 10% of the low birth weight in babies born to Black women is attributable to cocaine (Petiti and Coleman, 1990).

>RECOMMENDATIONS

What solutions can I recommend to the committee? I have three general recommendations: 1) Decrease the barriers to treatment, 2) Decrease the stigma of being in treatment, and 3) Decrease the need for treatment.

To decrease barriers to needed treatment I suggest that:

a) Treatment in all modalities medically established to be useful in the management of drug addiction should be made available in all localities.

b) A full spectrum of primary care services including child care, should be funded and available in all drug treatment clinics, so that the addicted mother with children and no working automobile can do "One stop shopping".

c) Travel vouchers or other transportation assistance should be readily available to all pregnant women, especially pregnant addicts, for whom a car breakdown can lead to a catastrophe such as Michelle's.

With respect to decreasing the stigma of being in treatment I remind the committee that most of us are addicted to one thing or another, be it alcohol, eating, cigarettes, running, work, or illicit drugs. Most of us compulsively engage in one or more potentially detrimental behaviors to modify our internal states of mind or mood. In this country many of us are dependent on medications prescribed by our health care providers for our continued life and normal functioning. The opiate addict successfully maintained on a daily dose of methadone to which she is tolerant, which keeps her free of illicit drugs and allows her to function successfully in her social and family roles is a treatment success, and should be recognized as such. Eventually some of these patients will be able to live drug free, but some will not. Some will return to heroin use every time their methadone dose is tapered and will need long-term maintenance. I would urge the committee and the American people to recognize that as long as the patient remains in treatment and free of illicit drugs she is a treatment success.

To decrease the need for drug treatment we must decrease the risk factors for drug abuse and addiction. The most important risk factor for drug addiction in America today is poverty. How will we create social structures that give other options to oppressed and despairing women besides the exchange of sexual behaviors for money and the use of illicit drugs for relief from the emotional pain of their day-to-day existence? I believe that we must create economic options for young adults in the inner cities and on the reservations that will provide alternative means of sustenance and self-esteem. Then, when they are offered a role in the seductive drug economy, be it as a supplier or a consumer, they will know that they do have something to lose by taking that first step. Maybe then they will be able to "Just say no".

Members of the Select Committee, I have asked you some difficult questions today, and would be happy to answer any of yours.

>REFERENCES

De Haas JH. Parental smoking. Its effects on fetus and child health. Eur J Obstet Gynecol Repro Biol 1975; 5:283-96.

Dixon SD. Effects of transplacental exposure to cocaine and methamphetamine on the neonate (special conference). West J Med 1989; 150:436-42.

Macgregor et al. Cocaine abuse during pregnancy: correlation between prenatal care and perinatal outcome. Obstetrics and Gynecology 1989; 74:882.

Meyer MB, Jonas BS, Tonascia JA. Perinatal events associated with maternal smoking during pregnancy. Am J Epidemiol 1976; 103:464-76.

National Center for Youth Law. Youth Law News, 1990; 11:19.

National Institute for Drug Abuse. Drug dependence in pregnancy: clinical management of mother and Child (Services Research Monograph Series) (DHEW Publication No. ADM 7-9-678) Rockville, MD: United States Department of Health, Education and Welfare. 1979.

Petiti DB, Coleman C. Cocaine and the risk of low birth weight. Am J Public Health 1990; 80:25-8.

Regan, Erlich, Finnegan. Infants of drug addicts: at risk for child abuse, neglect, and placement in foster care. Neurotoxicology and Teratology 1987; 9:315.

Simpson RJ, Armand Smith NG. Maternal smoking and low birth weight: implications for antenatal care. J Epidemiol Comm Health 1986; 40: 223-27.

Weitzman, BC. Pregnancy and childbirth: risk factors for homelessness? Family Planning Perspectives 1989; 21:175-8.

FACET PROGRAM

SAN FRANCISCO, CA

STATISTICAL DATA FOR FISCAL YEAR 1988 - 1989

TOTAL NUMBER OF WOMEN TREATED IN FACET 7/88 - 6/89		114
TOTAL NUMBER OF:		
Live Births	(1 set of twins)	55
Stillbirths	(23 weeks gestation)	1
SIDS		0
AVERAGE AGE OF CLIENT AT TIME OF DELIVERY		31
AVERAGE INFANT BIRTHWEIGHT		2,914 gms. (6 lbs. 7 oz.)
AVERAGE INFANT APGAR SCORES		7.6 - 8.7

BIRTHS BY GESTATIONAL WEEKS	No. Births	Gestational Age	%
	42	38 wks.	76%
	4	37 wks.	7%
	1	36 wks.	2%
	3	34 wks.	5%
	2	33 wks.	4%
	1	32 wks.	2%
	1 (Demise after birth)	30 wks.	2%
	1 (Demise after birth)	25 wks.	2%

INFANT WITHDRAWAL SYMPTOMS*	No. Babies	Severity of W/D	%
	4	None	8%
	13	Mild	25%
	21	Moderate	40%
	15	Severe	28%

*Thirteen of the infants in the moderate to severe category were given medication, therefor 75% of the FACET infants did not experience withdrawal symptoms severe enough to require medication.

AVERAGE DOSE AT TIME OF DELIVERY	33 mgs.
PERCENT OF NEWBORN URINALYSIS DRUG FREE EXCEPT METHADONE	57%
PERCENT OF NEWBORN URINALYSIS WITH COCAINE	25%
PERCENT OF WOMEN ATTENDING OB APPOINTMENTS	93%
PERCENT OF INFANTS PLACED WITH CLIENTS AFTER DELIVERY (N=1) Adoption - 2%	51%
PERCENT OF CLIENT STIMULANT FREE URINES	76%
PERCENT OF WOMEN ATTENDING REGULAR PEDIATRIC APPOINTMENTS	100%

Chairman MILLER. Thank you. Dr. Yoon.

STATEMENT OF JING JA YOON, M.D., CHIEF OF NEONATOLOGY, BRONX LEBANON HOSPITAL CENTER, BRONX, NY

Dr. YOON. I thank this committee for giving me the opportunity for me to see your interest in this tremendous problem and for giving me the opportunity to share with you my experience and observations in the Bronx, the South Bronx.

We had a feeling in the South Bronx that there is nobody who cares about newborn babies born to drug-using mothers. That's our common world every day, that nobody cares about these babies. I thank you very much for having this hearing.

I have been a neonatologist since 1970, first at King's County Hospital Downstate Medical Center in Brooklyn until 1976, and then I moved to Bronx-Lebanon Hospital Albert Einstein College of Medicine in the South Bronx. There I stayed until now, from 1977.

During this period of my practice I have taken care of over 2,000 newborn babies born to drug using mothers. The instance of infants born to drug-using mothers, self-identified drug-using mothers at Bronx-Lebanon Hospital increased dramatically from three percent in 1982, to 13 percent in 1988. There were 365 infants born to self-identified drug users in 1988, and at least 440 babies in 1989.

This increase was mainly due to increase in cocaine use. Currently over 90 percent of drug users are using cocaine alone or in combination with other drugs, and mostly crack.

The focus of my testimony today concerns the rights of the newborn. We had the feeling in the South Bronx that people are appropriately concerned about the rights of the mothers, but babies have rights, too, and we thought nobody was concerned about the babies' rights.

The babies are often born passively addicted, living their first days and weeks in the agony of withdrawal. They also suffer from many other problems related to the maternal drug use. Some of these problems will affect them for the rest of their lives. I would like to share with you some of my personal observations and experience, although it may take a little longer, not more than 10 minutes.

Mothers using crack are different from the other drug users. They are not teenage mothers, they are older. The mean age was 26 years of age. They are not first-time mothers, they often have other children. They do not plan for their pregnancy, 37 percent in our study group did not receive any prenatal care. Most of them, even if they received prenatal care, received inadequate prenatal care, three or four visits.

The majority of cocaine users smoke cigarettes heavily, smoke marijuana, drink alcohol as well during their pregnancy. Many had sexually transmitted diseases such as syphillis, gonnorrhea, hepatitis B and HIV infection, which can also be transmitted to their newborn infants.

Many cocaine-using mothers seem to have little concern about their babies. Heroin mothers 10 to 20 years ago always wanted to take their babies home, "When can I take my baby home?" "Can I take," "Is my baby okay?" Even though they go home and get

heroin, they come back the next day, they want to know how the baby is and they wanted to take their babies home.

Women on crack don't. They sign themselves out on the same day of the delivery or next day and they disappear. Babies are often left in the hospital and we cannot even locate their mothers in many occasions. They may come back next year or within six months or seven months to deliver another premature baby, and they disappear within one day again. All these mothers care about seems to be to us that they want to get crack. That's their priority.

Babies born to drug using mothers are often born prematurely, have lower birth weight, have in utero growth retardation, small heads, congenital malformations, sexually transmitted diseases and abnormal neuro behavior during the newborn period. Approximately 28 percent of babies born to drug-using mothers have sero positivity for HIV. About one third of them eventually develop AIDS.

Even after counseling, HIV infected mothers continue to get pregnant. Babies born to cocaine users do not interact well, even during the newborn period. This was manifested by abnormal tests. They have small heads, of a normal electroencephalogram of a normal cranial sonogram and cerebral infarcts in addition to the prematurity, in utero growth retardation and congenital infection, which will affect these infants in their future growth, development and behavior.

On any given day in our hospital there are about 15 babies in our nursery waiting to be placed. More than half of them were abandoned by their own mothers. Their mean hospital stay is approximately 27 days. The numbers of days on social hold increased from two days in 1982, to nine in 1987. For the last six months it has increased to 16 days.

In 1987, there were 271 infants born to drug-using mothers, and their care cost $2.5 million, and it is increasing every year. It did not level off in the South Bronx. The future cost to society for the care of these children will be enormous.

Education is the key, I believe. We need to educate pregnant woman to receive prenatal care, not to take drugs, not to smoke, not to drink alcohol, and to care for themselves and their babies.

They need to receive more prenatal care, and we need to lessen barriers to care by providing easy access to food supplement programs and others services in the clinic, and home visits by visiting nurses. Education should start before their pregnancy and before even they use drugs, starting from kindergarten, even nursery school.

We need to conduct drug screening tests on all pregnant women and all newborn babies, especially those born to high risk mothers who have had no prenatal care, who have a past history of drug use or who admit to drug use or marijuana use or who are high. It is particularly necessary in a community like ours, which has seen an epidemic of drug use at this time.

Presently, routine drug screening tests cannot be conducted on all newborn infants in New York State because of concern about the mother's right to privacy. Many drug-using mothers deny any drug use and do not give the doctor permission to test them and their babies for drugs. We tested 200 consecutive pregnant women coming in in labor anonymously for drugs, 30 percent of them tested positive.

During the same period the incidence of self-identified drug users was only 13 percent. This indicates that more than half of drug users deny drug use. We need more drug treatment programs for pregnant drug users and homes for their babies until their mothers are rehabilitated. These crack users particularly do not have patience, they don't want to wait one minute.

If we took our time to explain to them how important it is to get into the drug programs, they may say yes this moment, but they turn around in two minutes they will say they will not go or they may have disappeared. So we have to take them right that moment.

I am not in favor of putting pregnant women in jail, as many other people. I see the need in some cases for placing pregnant addicts in supervised maternity homes to help get the mother off drugs and to insure the baby is born drug free. This is, I believe, the most cost effective preventive measure for the newborn babies our future children, our future Americans to be born drug free, born unharmed by maternal drugs.

We also need to continue follow-up studies to see the long-term effect on the infants as well as on their mothers if they became truly drug free. We need to remember that babies have rights. We should not look at the problem of maternal drug use solely as the mother's problem, because her problem is her baby's problem as well.

I thank you.

[Prepared statement of Jing Ja Yoon follows:]

PREPARED STATEMENT OF JING JA YOON, M.D., CHIEF OF NEONATOLOGY, BRONX-LEBANON HOSPITAL CENTER, BRONX, NY

I have been a neonatologist since 1970, first at Kings County Hospital Center/ Downstate Medical Center in Brooklyn where I was until 1976, and then at the Bronx-Lebanon Hospital Center-Albert Einstein College of Medicine in the South Bronx from 1977 to the present time. During this period of my practice I have taken care of over 2,000 babies born to drug using mothers.

The incidence of maternal drug use at the Bronx-Lebanon Hospital Center has increased dramatically from 3% in 1982 to 13% in 1988. There were 365 infants born to self-identified drug using mothers in 1988 and at least 440 in 1989. This increase was mainly due to the increase in cocaine use. Currently, over 90% of drug users use cocaine and mostly crack.

The focus of my testimony today concerns the rights of newborns. People are appropriately concerned about the rights of the mothers, but babies have rights too. The babies are often born passively addicted, living their first days and weeks in the agony of withdrawal. They also suffer from many other problems related to their mothers' drug use. Some of these problems will affect them for the rest of their lives.

Let me share with you some of my personal observations and experience. Mothers using crack are different from the other drug users we saw in the 1970's when we mostly saw heroin and methadone addiction. They are not teenage mothers; they are older, the average is 26 years of age. They are not first-time mothers; they often have other children.

They do not plan for their pregnancies; thirty seven percent of them did not receive any prenatal care and most received inadequate prenatal care. The majority of cocaine users smoke cigarettes heavily, smoke marijuana and drink alcohol as well during their pregnancy. Many have sexually transmitted diseases such as syphilis, gonorrhea, hepatitis B and HIV infection which can also be transmitted to their newborn babies.

Many cocaine using mothers seem to have little concern for their babies. Heroin mothers, 10-20 years ago, always wanted to take their babies home with them, but women on crack do not. They seem to have lost their maternal instinct and they don't seem to care about their babies. Babies are often left in the hospital and we are often unable to locate their mothers. All these mothers care about seems to be getting more crack.

Babies born to drug using mothers are often born prematurely, have lower birth weight, in-utero growth retardation, small heads, congenital malformations, syphilis, hepatitis B or HIV infection and abnormal neurobehavior during the newborn period. Approximately 25% of babies born to drug using mothers are seropositive for HIV and about one third of these infants will develop AIDS. Even after counselling, HIV infected mothers continue to get pregnant.

Babies born to cocaine users do not interact well even during the newborn period, as manifested by abnormal Brazelton tests. They have small heads, abnormal electroencephalograms, abnormal head sonograms, cerebral infarcts in addition to the prematurity, in-utero growth retardation and congenital infection which will affect these infants in their future growth, development and behavior.

On any given day there are about 15 babies in our nursery waiting to be placed. Their mean hospital stay is approximately 27 days. The number of days on social hold increased from 2 in 1982 to 9 in 1987. In 1987, 271 infants were born to drug using mothers and their care cost $2,457,000.00; and it is increasing. The future cost to society for the care of these children will be enormous.

Education is the key; we need to educate pregnant women to receive prenatal care, not to take drugs, not to smoke, not to drink alcohol and to care for themselves and their babies. They need to receive more prenatal care and we need to lessen barriers to care by providing easy access to food supplement programs and other services in the clinic, and home visits by visiting nurses. Education should start before their pregnancy.

We need to conduct drug screening tests on all pregnant women and all babies, especially those born to high risk mothers who have had no prenatal care, or who have a past history of drug use, or who admit to drug or marijuana use, or who are "high" at the time of delivery. It is particularly necessary in a community like ours which is seeing an epidemic of drug use at this time.

Presently routine drug screening cannot be conducted on newborns because of concern about the mother's right to privacy. Many drug using mothers deny any drug use and do not give the doctor permission to test them and their babies for drugs. We tested 200 consecutive pregnant women anonymously for drugs. Thirty percent of them tested positive. During the same period the incidence of self-identified drug users was only 11%. This indicates that more than half of drug users denied drug use.

From our study on 875 infants of self identified drug users we found many adverse effects from maternal drug use which required special intervention. It is ,however, not clear as to whether cocaine itself or other factors are responsible.

We need more drug treatment programs for pregnant drug users and homes for their babies until their mothers are rehabilitated. I am not in favor of putting pregnant women in jail. But I see the need, in some cases, for placing pregnant addicts in supervised maternity homes to help get the mother off drugs and to ensure that the baby is born drug free. We also need to continue follow-up studies to see the long term effects on mothers and their babies.

We need to remember that babies have rights. We should not look at the problem of maternal drug use solely as the mother's problem, because her problem is her baby's problem as well.

Chairman MILLER. Thank you very much for your testimony.

Let me, if I just might, I'm going to ask this to all three of you, you obviously have a range of clientele here that may be helpful to us. Again, the question that haunts us here is obviously, as policymakers are people who are held accountable at some level or another for what we do, what are we talking about in terms of success.

As I mentioned, in different circumstances it may be measured in different ways, but again, just as I'm worried about the stereotype of the mother, I'm worried about the stereotype of what it is that must be achieved before we would invest in that program. I wondered if you might just help us a little bit with some of your thoughts, given the women that you have worked with. Can you help us? Maybe you can't.

Ms. SMITH. I think the most important indicator of success in this area, of course, is a drug-free pregnancy. That's the goal we all have. I think you have to look at multiple indicators, you have to look at the extent to which that woman is trying to repair her life. Relapse is not a complete failure.

I think this has been pointed out by some of the other speakers, in that when you're dealing with chronic illness relapse will occur. What you need to look at is how often those relapses are occurring, how long they last. As the woman begins to get further along in her recovery, those are going to become less and less frequent, they're going to become of shorter and shorter duration.

Again, we're not talking about something you can cure in 30 days. We're talking about something that will take time for complete remission. I think it's important to look at parenting behaviors when you're working with the mother and there are ways to assess effectiveness as a parent, knowledge of child development, her follow through with therapeutic interventions. All of those things are appropriate outcome measures.

Dr. TRACHTENBERG. If we're going to talk about success, let's first talk about it in general and then specifically in the pregnant women.

Chairman MILLER. However you want to talk about it.

Dr. TRACHTENBERG. I think in general success, what you're going for as you treat a particular patient, is going to depend where they start. For the heroin addict who is out on the street, using, never been in treatment, there is one step of success when they call up, get on the waiting list, get in and get admitted to a program, even a detox program, a methadone detox for the first time.

That's a success because they've actually admitted they have a problem, they need treatment. They come in contact with a health care provider, they get a physical examination, they get laboratory work done. They get told that their liver is terrible because of the drugs they've been using and the drinking they've been doing or whatever.

Everywhere from there to if you have someone—oh, they're usually seen as failures, by the way, because as has been said before 21 or 30 days is not long enough to change your whole lifestyle from being a drug addict addicted to anything to get back to fulfilling your social role successfully and not needing to compulsively use a substance. So it may be seen as a failure in that way.

Usually what people have to do, what heroin addicts need to do is go through several rounds of detoxification and only then, in fact, are they eligible for maintenance. Now if you had six months or a year to work with an addict, that gives you some time to really help them change in some way; a month isn't enough.

Eventually I feel it's a success if you have an addict who is maintained on methadone, who is not using illicit drugs, who is fulfilling family and societal roles successfully, and if they need to take methadone every day to fulfill those roles—well a lot of us need to take medications every day, a lot of us have behaviors we compulsively indulge in every day like running, work, alcohol, cigarettes. I think they should be seen as a success.

Now once they're at that stage if they can be gotten off methadone entirely, if they can get drug free, that's even more of a success, because some of them do need to be maintained on methadone. Whenever you drop their dose they may begin using heroin again. We try tapering them and after two or three attempts at tapering, if it's not successful you don't want to mess with the success you've already had.

Now what about pregnancy in particular, what's success in pregnancy? I feel that if you get a term delivery of a non-growth-retarded baby that doesn't have severe withdrawal and has not been too damaged by cocaine, tobacco and alcohol, I think you've done pretty well with the baby of that addict, and that's a success.

We've got to keep this in perspective. Smoking cigarettes causes a lot more neonatal death than cocaine does in this country. We're not talking about smoke-free, sea level prenatal camps to keep women from harming their fetus in those ways.

Chairman MILLER. Let me ask you—excuse me, go ahead, then I want to come back to what you said about the pregnancy, Dr. Yoon.

Dr. YOON. Thank you. I see five different areas we can talk about, whether we succeeded or not. One, I will talk about research; two, prevention; three, identification; four, treatment; five, follow-up. We have some data on research on immediate outcome of the maternal drug crack use, alcohol, a lot of data on maternal alcohol use and smoking. However, we do not have data on long term outcome.

We do not have data on long term outcome on the drug users themselves. We still need to do a lot of research, and until we know a lot more, I guess we have a long way to go. Prevention, I guess it's going to take a long time, but as a neonatologist or pediatrician, I think prevention is one of the most important keys. We have to start early.

Identification—I'll make it very short, as short as I can—we need to identify who is taking drugs, as you heard some of my experience that more than half of drug users deny using drugs. We have to identify them. I guess it's going to happen not only in pregnant women, but also in other areas.

Treatment, there is a lot more research to be done. How to treat these women, pregnant women before they get pregnant for them to be drug free or alcohol free. When babies are born, even normally we don't know what's going to happen, what kind of treatment would they need for them not to be drug addicted. We need a lot of

follow-up study, not one year, not two years, not five years, 20 or 30 years.

It may seem to be a successful story now, in five years you may have a healthy, normal child, you can still have without any treatment program, that some of these heavily crack addicted mothers may seem to have a normal, healthy newborn child. In five years they may be normal, but in 15 years they may be a drug addict.

So we need real long term follow-up studies to know what's going on. Meanwhile, we need to give them care for the babies and mothers. Make it easy for the mothers to be in the program and meanwhile these babies can be taken care of by various people. There is no such good program or many programs. Maybe there is one or few private programs or different areas.

In the Bronx there is no program for the children who are abandoned by their mothers. They are in foster care and sometimes moving from one foster care to the other foster care, in three years they are still there in foster care because their mothers are still not rehabilitated.

Chairman MILLER. Thank you. Is it conceivable to all of you that we may very well in some instances experience failure and possible success at the same time, that we may lose this mother and this baby during this immediate pregnancy, but if we stick with them we may conceivably avoid a reoccurrence of that same situation?

I mean, we look at some programs with teenagers and pregnancy where we get them during their first pregnancy and what we're able to do is postpone the second pregnancy for a longer period of time than children who weren't in those kinds of programs.

Is it worth the effort, again in terms of the investment we're talking about making here to recognize we may not make it with each and every pregnancy or hope to make it. Is that worth the prize here?

Ms. SMITH. I think it is. We're already beginning to see that happen with some of the women that we're working with, in that they came to us fairly late in one pregnancy actively using, got pregnant again and didn't use or went into treatment immediately when they found they were pregnant. We saw that with our alcohol-abusing moms as well when we were doing our research on prenatal alcohol use.

Some of those mothers came through with second and third pregnancies in which they didn't use alcohol. They had started out in the experimental group in the study we were doing and in the second round wound up as controls. It does happen.

There is a positive effect to education. Many of the mothers that we work with don't understand addiction, I think as Kathleen pointed out in her testimony. Many of them have had very little, if any experience with treatment, so they come to us with a lot of misconceptions about what drug treatment is.

There is a lot of stigma, there is a lot of fear. Educational interventions can get beyond that so that when the woman recognizes that she needs help the next time around, she'll know where to go and how to go about getting it and the fear and stigma won't be there or won't be as great.

Dr. YOON. Sure. It's better to be late than never, but if you can be on time it's even better. In Kathleen's case she had one fetal

alcohol syndrome child, she lost two children and she has two normal children. Do we call that a success? I think we have to think of it very, very hard.

We could have prevented those two children who died from dying. We could have prevented the fetal alcohol syndrome case if we could identify her problems earlier and given her treatment early. Prevention should be the most cost effective for the future, for the success you're asking for.

Mr. HASTERT. Thank you, Mr. Chairman.

Dr. Yoon, that was a very good testimony and I appreciate your being here this morning. How can you treat the babies? Is there an ability to treat babies that have been born to mothers with crack? I mean, you talk about the almost irreparable damage that these children suffer physically, let alone what happens down the line that you can't test for and we can't predict, but what can you do for these babies that are already born to crack or heroin addicted mothers?

Dr. YOON. Well, I think we can give help to these children in many ways. We can start if prenatal care is—if we lost the time giving care from the conception time but we have a baby born to an addicted mother or drug users, we can start giving them, I guess, the medical treatment which is available, now premature babies are becoming normal as far as IQ is concerned or developmental quotient is concerned.

Mr. HASTERT. Is there a possible prognosis then that could happen?

Dr. YOON. Sure. Plus we can provide a loving home or we can provide a temporary home until the mother gets rehabilitated and we can send these children back to the mother if that occurs within two months, three months or a year or two years. Whenever it occurs it can bring back to there and babies can be brought to their parents.

If that's possible, that's the best way. There are many other early stimulation programs which I believe very much and I do think they do change their outcome a great deal. They become normal human beings or they at least can develop up to their potential. Every year the medical management has been improving and the outcome has been improving, therefore as we do more research, more care for these children we come to know more about them, we will do better.

Mr. HASTERT. So really one of the things that's most important is a loving, nurturing environment or family to really take care of this child; is that correct?

Dr. YOON. That's correct.

Mr. HASTERT. One of the problems you described stems from these children being bumped around from one foster home to another.

Dr. YOON. Sure. At least in the South Bronx.

Mr. HASTERT. I don't want to generalize the whole country from the South Bronx. In your experience, do you think that one important action to take for the child's sake is to get them into a loving, nurturing family as quickly as possible. Is it possible that limiting parental rights and lessening the time it takes to get the child

from a foster care situation into an adoption situation is good for the child?

Dr. YOON. In some cases, yes.

Mr. HASTERT. How do you determine when you should do that and when you shouldn't do that?

Dr. YOON. I don't know, but I can tell you one mother, if I'm allowed to tell?

Mr. HASTERT. Sure.

Dr. YOON. Baby W was born to a mother who just came in. She had crack and came in and had abruptia placenta and delivered, 24-weeker with congenital syphillis. I went to talk to mother and I explained the baby's medical history and how sick the baby was. "Would you like to see the baby?" She said "No."

"Have you ever had any rashes during pregnancy?" She did not have any prenatal care, so I had to ask her all the questions. She said, "Sure, look at me," and she opened her legs. I thought it was syphillis, but we did not have any history of syphillis, she was never treated. Within 12 hours this baby died and I went down to talk to the mother and she disappeared.

In six months she came back with exactly the same story and she delivered the baby in the admitting office because it was just too late. The baby was resuscitated, brought to us and when we went back down to the admitting office, she disappeared. So she was never treated for syphillis. With this child we knew right away and this child was 26-weeker, 700 gram baby who lived. After all this, this mother never visited and it was adopted by one of our hospital staff and the child is doing beautifully.

I wonder if you can call this a success story from the child's sake or view, or can you call this a failure because she may come back again, or she may go to another hospital without giving any history at all.

Mr. HASTERT. Certainly we have problems before us.

Chairman MILLER. Would you yield.

Mr. HASTERT. Sure.

Chairman MILLER. I think on that point, because that story and similar stories that I've heard and I think members of the committee have heard when I've talked to professionals in the field, and certainly people working in the South Bronx or other difficult neighborhoods and environments is sort of a public policymaker's nightmare. You start to feel yourself get a little angry and upset with that mother at a minimum.

Dr. YOON. Right. Chairman, that's not every case.

Chairman MILLER. No, no, and I understand that. My concern in addressing it is immediately to try to sugggest that that's not every case, but I worry that those cases are driving public policy considerations; the perception that each and every crack mother, epecially from inner cities, are these women who don't care about these babies so we should be locking them up and that's driving this.

As I think we've seen here, and we'll hear in later hearings, this is a cross section of America, this is a lot of different things happening. My concern is—I guess what my colleagues would say to me if I tell this story in the congressional dining room, they say to me, "What are you going to do?" My answer is, I don't know.

Dr. TRACHTENBERG. You know when you hear those kinds of stories, when I hear them, I want to ask how did the mother get that way.

Chairman MILLER. I understand.

Dr. TRACHTENBERG. Did she have any possible source of self-esteem or even material sustenance other than——

Chairman MILLER. You're anticipating our next hearing. I understand that, and I was going to ask Iris and ask you, because you don't work in that particular environment—you can take that story and say South Bronx and people say get me out of the room, I don't want to talk about it.

Now let's go to the situation in Atlanta. We're being driven by this depiction of crack users I think Dr. Yoon has shown us. She has cited her caseload and what they have found at your hospital in the South Bronx. How do we figure this into the equation?

Ms. SMITH. Well, I think there's one problem here in the way we conceptualize cocaine abuse, too. When we talk about alcoholics or we talk about people who drink alcohol, we don't necessarily classify everybody who drinks as an alcoholic. When we start talking about cocaine it's as though we're talking about the same person over and over again.

In point of fact, there's a lot of variability. Many of these women had, for example, problems before they became addicts, which only become exacerbated once they begin to use drugs. They are at varying levels of impairment. It's a heterogeneous population. There are some cases like that that we all see, but they certainly are not all like that. They certainly are not all hopeless.

We see a number of women, as I mentioned before in our area treatment is very, very limited, a number of the women, in fact all of the women who come to our program do so voluntarily. We carry a caseload of 100 women, none of these women are court referred. They have all come to us because they are seeking help and because they are concerned about their children.

We see a number of those women who quit using on their own and struggle with that with very minimal support. We provide support groups in the communities and we're also working actively with church groups to develop other community based supports for these women. Many of these women can be succesful with relatively little intervention.

I'm not talking about the same kind of individual that Dr. Yoon was talking about, although those women exist, so do the women we work with, many of whom will have very positive outcomes to their pregnancy, many of whom who will be very good parents with parenting education support, with after care support.

Again, we're talking about a wide spectrum, and we're not talking about one solution, but many for different types of individuals.

Mr. HASTERT. If I may reclaim my time, you're talking about people who are really committed to keep the child, they have a love for the baby.

Ms. SMITH. Right.

Mr. HASTERT. Dr. Yoon is talking about people who want to walk away from the situation and virtually do it. I remember a couple of months ago or maybe a year ago now, we had people from hospitals right here in hospitals in Washington, D.C. talk about scores of

31-228 0 - 90 - 5

mothers who have no love or affection or desire to mother their child and they walk out the door.

So I think we need to have legislation in place and programs in place for those who want to help themselves and their child and are willing to take on that tremendous burden—programs where they learn to take care of themselves so that they can take care of the children.

For those who don't wish to do that or disappear into society someplace, then we need to be concerned about the rights of those children. I might say that I think those babies have rights, too, to not be shuttled around from one care organization to another. That they have the right to have a family and love and nurturing so that we don't repeat that cycle over again.

I think, Dr. Yoon, you've brought that out very well. Thank you.

Dr. YOON. I think we need both. There are mothers who are willing to be rehabilitated and they can be successfully rehabilitated. There are mothers who are not willing, not willing to even listen to you. We try to explain to them, and taking our time, but because of case overload and because there is no reimbursement for education for these women, I think it's the most vulnerable time right after delivery because of the nature of the maternal instinct I think that's the best time to get them.

Educate them so we can, perhaps, prevent——

Mr. HASTERT. Maybe we can find a way to stretch out that maternal instinct from them.

Dr. YOON. Right. Some of them are destroyed, but a lot of them are not destroyed. A lot of them are not and a lot of them still do have instincts. So when I say a lot of them don't, it doesn't mean everybody. A lot do have it. For those who have, still there is hope to rehabilitate them. Once they come to your program on their own, you should have very good results.

Mr. HASTERT. Once they walk into that as a volunteer, into that program, they've made a commitment?

Dr. YOON. Right, they have a will to be cured. In spite of that Kathleen had a difficult time, a long time.

Mr. HASTERT. If I may add Kathleen X is not typical of a lot of the women that we're talking about here that come out of the ghetto. She came from an environment that was very different, and yet, we see substance abuse occurs across societal bounds.

Thank you very much.

Dr. YOON. Thank you.

Chairman MILLER. Thank you very much. I think in the committee's effort to focus on the women and the treatment and rally their environment, this is not an effort to pit the rights of the women against the child. The concern here is that the child has little or no control over this problem and the treatment and prevention seem to me to be the best ways that we can enforce the rights of the child, because the child can't say stop, the fetus can't say, "Stop, this is hurting me."

So the question is how do we get these women out of that drug-abusing environment, or alcohol-abusing environment, or tobacco-abusing environment to protect that child.

My concern is that I worry that the debate is shifting and focusing on the child as a byproduct or the result and, therefore, we

want to go back and punish somebody for this result. That may, in fact, happen. Again, the prevention of that child being born low birthweight, defective in any fashion, drug addicted, alcohol addicted, tobacco addicted, would be the goal that we want.

So I just worry that before we get into focusing on 375,000 babies and, therefore, we've got a problem, we've got to say how did we get the 375,000 babies. I don't know if I'm making this clear, but trying to look at it from how to prevent the mother engaging in this abusive and harmful activity, that then we can reduce that number.

To have that mother walk out of your receiving room is just to wait another six or seven months until she's back again in all likelihood. Maybe you'll never know it because she may not come to your hospital and may go to another hospital.

Dr. YOON. Or she may die from AIDS.

Chairman MILLER. She may die from AIDS or her next child may die from AIDS. So it's an effort to try to think what is it we can do that would prevent this behavior from taking place and the coping with it—if we come into the middle of the story—once we are able to identify it.

Mr. HASTERT. Would the Chairman yield?

Chairman MILLER. Sure.

Mr. HASTERT. I think you hit the nail on the head, but I think you also articulated quite well that there's several levels of problems. When I wrote the Child Abuse Prevention Act in Illinois in 1983, we had to realize that we had mothers who had problems, and with some mothers, it was a generational problem. They were abused children and the next generation is right around the corner. Those first crack babies, those first heroin babies, those first drug related babies are out there having babies themselves.

So if we can first of all take those children who are really in an unwanted situation and stabilize them, you've started to look at part of the problem. I don't think anybody wants to put pregnant women in jail, nobody wants to do that. You're right, you have to take those people voluntarily, but sometimes there's not a lot of volunteer feeling about that. We have to get them and get them in the program somehow.

We have to stop the cycle of second and third and fourth round children from being born to drug addicted mothers. I think that's the issue. We just can't say well, it's a mother's issue or a baby's issue. We have to take care of everybody. Right now the focus is on the child who didn't want to be born as an addict.

The baby didn't want or choose that. And yet, we must help that baby who is now here and salvage their future. Then we need to take care of the mother and try to get them on the programs.

Chairman MILLER. This isn't an argument because we shared an experience at the state level, you also provided for the termination of parental rights when it was in the interest of the child, and I fought that fight in 1978, in the Congress. I remember the uproar over the notion that we were going to somehow suggest that parental rights were going to be subservient to the right of the child.

In fact, current law allows for the protection of that child. What I don't see in current law is preventing that child from coming into existence in the future, tyring to deal with that. Once we have this

damaged child, we can terminate those rights in short order, we can find a foster home. I'm trying to figure out what it is we can do to prevent the child from coming into existence in terms of a child that needs the foster home, in terms of educating these mothers in prevention that Dr. Yoon and others have talked about.

I just don't want people to walk out thinking that we've now decided that this is pitting the child against the mother. That's not what this hearing is about, it's to try to think about——

Dr. TRACHTENBERG. You know I'll tell you there's one thing that certainly can be done, well unfortunately is being done right now that is going to make the problem worse, and that is prosecution of pregnant women. Now in Butte County we know of at least one woman who not only avoided prenatal care, but delivered at home because she was on drugs and afraid that if she got into prenatal care the word would get back to the district attorney and she would be prosecuted.

You have to look at what the effect of a policy is going to be when you make a women scared that you're going to take away her child. Maybe she'll avoid prenatal care. I think this is the kind of thing that I see happening with moms like Baby W's. You know, if when they come into the hospital they get treated like scum, why are they going to come back to the hospital, except when they absolutely have to?

There is no incentive and a lot of barriers and a lot of reasons that Baby W's mother maybe didn't want to come into the hospital until she absolutely had to. We need to lower those barriers, not increase barriers of fear.

Dr. YOON. I had that feeling perhaps five or six years ago. We had a lot of caseload in our hospital and maybe by preventing them is crucifying them is worse. Because of my feeling all of our staff tried our best, real best, to send the babies home. That was our goal in our social service round, in our daily round. So we spend our staff spent night courses for the mothers, we thought a lot of mothers were pretty good.

They came in with clean clothes, they came every day, they seemed to be very interested. We used to send a lot of babies home without even consulting the special services for children or without sending visiting nurses home. We have had many unsuccessful stories as well. We have successful stories, too. When it becomes unsuccessful, what it means is this baby is—we didn't even know mother did not have a home, because we just believed in her.

She will be all right a few days, she may not be all right a few days. It's only a few days we are talking about when she is not okay, she will go into the crack house and stay there for a few days and this baby is left at home without any attendance. It was found by superintendent or some mothers leave this baby in a box at the hospital with tags on the baby's chest that this baby was born at Bronx-Lebanon Hospital on such and such a day, and she disappears.

So the emergency physician calls us and we had to locate the father, and luckily in that case we were able to locate the father and we sent this baby to the paternal grandmother.

So that no matter what system we have, we will have some success and some failure. In what way can we succeed most? When we

say unsuccessful or failure, does it mean child death, or does it mean the child is frozen and dies in the apartment alone, or does it mean going to a foster case home and another foster care home. That's a failure, too.

Also sometimes we have to weigh which failure is worse than what. When we talk about success as well, any aspect when you talk about it, there is a real success case and just a little successful case or a delayed success like Kathleen. I think can't we not do both?

Chairman MILLER. If you keep posing these tough questions, you're not going to get invited back.

Iris. [Laughter]

Ms. SMITH. I was going to say pretty much the same thing. It sounds like, "Well, here are all the things we can do and we'll now pick one." It's going to be very hard to pick one. I think there is another issue here, which is we really don't know a whole lot about the long term development of these crack exposed babies, although we talk about them as though we know what that means, we don't.

There needs to be more research done to really see what kinds of developmental problems these children will have. One of the ramifications of that is that we're beginning to have mothers come back to us terrified that they've got a child that's profoundly mentally retarded. We don't know that that's true.

Many of these moms who run away from these kids, who abandoned them, are afraid that these children are irreparably damaged. We don't know that that's true. Again, we have to be very cautious in making those kinds of statements until all of the data are in, and they aren't in at this point. We still have a lot to learn.

Chairman MILLER. Thank you. This has been very helpful, because I think the goal is to sort of pull, as we said, the stereotype apart, and maybe expose it to a little bit more light and see if we can develop policies that are a little more custom fitted to a very difficult caseload at whatever end of the spectrum they are.

Thank you very much for your time and your help on this. As I said at the outset, this is one in a series of hearings that we will be having, recognizing that a number of other committees are in the process of developing legislation, responses, modifications and reforms of existing programs that we hope to be able to translate this into effective responses to the problem.

Thank you very, very much. The committee will stand adjourned. The next hearing will be Monday in Detroit.

Thank you.

[Whereupon, at 12:35 p.m., the select committee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF BARBARA W. LEX, PH.D., M.P.H., MEMBER, AMERICAN ANTHROPOLOGICAL ASSOCIATION TASK FORCE ON ALCOHOL AND DRUGS, ASSISTANT PROFESSOR OF PSYCHIATRY (ANTHROPOLOGY), HARVARD MEDICAL SCHOOL, BOSTON, MA

This testimony was condensed from a much larger summary and review of sociocultural, psychological, and biological factors contributing to gender differences in substance abuse.[1] During the past ten years our multidisciplinary research group at the Harvard Medical School-McLean Hospital Alcohol and Drug Abuse Research Center has conducted numerous studies of substance abuse effects in *women who use alcohol, marijuana, cocaine, or opiates*. Many women were found to abuse more than one substance, and many also reported having a family history of alcoholism.

Prevention and Intervention

Predisposing sociocultural factors, biological factors, and pharmacologic effects of substances all interact to exacerbate substance abuse problems.

1) Cultural factors. There is evidence for and against cause-and-effect relationships between life crises and substance use. Those who counsel women experiencing stress should be aware of potential risk. Preventive strategies could include increasing public awareness that people often try to relieve distress with alcohol or illegal drugs, and publicizing appropriate resources for solving problems. Male partners also can exert a social influence by providing alcohol and drugs. The environmental distortions that accompany a family history of alcoholism or other substance abuse may perpetuate these problems in the next generation. Studies of social drinkers and casual substance users indicate that harmful effects, such as behavior changes and increased consumption, can occur before substance abuse is seen as a problem. All of these findings point to strong needs for early prevention and treatment targeted to women.

2) Biological factors. These include possible genetic effects of family history of substance abuse, presence of psychological disorders, such as depression,[2,3] and reproductive dysfunctions, such as infertility, miscarriage, or stillbirths.[4,5,6] There may be close to 28 million children of alcoholics in the United States,[7] and slightly more than half are women.[8] Many people have become aware of the high risk conveyed by their familial and genetic legacy, and the magnitude of this vulnerable population invites an educational initiative. There is a strong need to raise public

awareness about the connections between depression and abuse of substances to alter moods, and the impact of substance use on the capacity to conceive children and to have normal births.

3) Pharmacologic factors.

While pharmacologic effects of substances may appear more clear-cut than sociocultural or biological factors, all intersect. Family history of alcoholism may convey a differential sensitivity to the effects of alcohol,[9, 10] and perhaps to other substances.[4, 11] Further, the unpleasant mood states that accompany heavy drug use[4, 12, 13] also have a significant impact on psychosocial factors. One key study[14] found that social drinkers who abstained during a 90-day study reported improved moods after they stopped drinking. Thus, there is also a strong need to increase public awareness of the adverse consequences of substance abuse on moods and behavior.

With all of these interacting factors, it is important to choose appropriate interventions.

- Prevention strategies could begin by increasing prenatal care for high risk women, as well as providing case management for their ongoing health care, social service, day care, employment, and financial assistance service needs.
- As girls mature it is important to include information about substance abuse effects in education about reproduction. Information about possible influences from male partners who might encourage substance use should be available by the time young people begin to date.
- Targeting substance abuse prevention programs to 11th and 12th graders is important. However, since many high risk girls leave school, they need specially-focused outreach services.
- If reproductive dysfunction is related to excessive drinking or other substance use, then obstetrical and gynecological practices are good potential resources for patient education. Physicians, nurses, and other primary health care providers should be encouraged to ask specific questions about substance abuse as a basic part of a woman's medical history.
- Programs treating female substance users also should evaluate the status of reproductive hormones in their patients. This strategy could promote intervention in medical problems that are now rarely recognized, and improve both maternal and child health.

* Outreach programs targeted to vulnerable populations, such as pregnant teenagers, are other important contexts for providing information about consequences of substance abuse.

* Substance abuse treatment programs often include a family therapy and/or marital therapy component which should provide information specifically targeted toward women to explain the many detrimental factors in relationships between male and female substance abusers.

These approaches all intersect with emerging ideas of changing female roles, including assertiveness and limit-setting skills, and the ability to form independent social judgments. Women's demonstrated needs for social supports[15, 16] argue for "inoculating" vulnerable women by increasing their awareness of interpersonal relationships and using support groups as a treatment strategy. *In summary, creative prevention efforts would examine existing programs and identify information and interventions targeted to girls and women who are at risk for substance abuse and its deleterious effects on themselves, their offspring, their families, and society at large.* These recommendations are based on the following findings from my own research as well as drawn from the research of others.

Gender Differences in Polysubstance Use:

A combination of factors contributes to women's substance abuse,[1, 11] including many differences between women and men identified a decade ago.[17] Women have fewer assertive skills and need more support from social relationships. Their social status still generally derives from men (e.g., fathers or husbands), and their drug supplies are also likely to come from men, whether their sexual partners or physicians. Typically, women are expected to play more key family roles, and are responsible for nurturing children as well as for birth control. Women have fewer job options and lower paying jobs. Women also report more medical problems, and are perceived differently when they seek care. Women who engage in deviant behaviors receive more social criticism and stigma, and have different experiences with the criminal justice system. Women who use drugs are likely to have been sexually abused, but most treatment programs are focused to meet the needs of men.

Current Epidemiology

A cross-sectional household survey of alcohol and other drug use was conducted in 1988.[18] Findings were reported by drug, gender, and age groups. To summarize, a majority of all American women (63.3%) said that they had used alcohol within the past year (versus 68.1% for men), and slightly less than half (46.7%) had used alcohol within the past month (versus 60.0% for men). For ages 18 to 34, rates of lifetime use were 84.5% for men and 77.9% for women. *Roughly 15% of women and 40% of men said they drank at least once a week.*

In addition, 61.7% of all adults ages 18 to 34 reported that they had used an illegal drug at least once in their lifetimes, and rates in this age group were similar for men (64.4%) and women (60.0%). Men were more likely to continue their use, since 10% more males than females ages 18 to 34 had used an illegal drug during the past year, and 7.3% more males than females, within the past month. *Fully 25% of both boys and girls ages 12 to 17 had tried an illegal drug.*

Women Receiving Mandated Alcohol or Polysubstance Abuse Treatment

Although the relative contributions of psychosocial and biological factors to adverse consequences of substance abuse on reproduction are not yet fully known,[19] our work with 20 women civilly committed to alcohol and drug treatment [4, 6] illustrates the numerous complex and severe problems that affect women whose need for substance abuse treatment is sufficiently compelling to be brought to the attention of the courts. A large number of these women had hormonal disruption, reproductive dysfunction, and a family history of alcoholism. Further, they typically had low incomes, and some had had encounters with the criminal justice system. About half had been victims of assault, rape, or incest.

Substance abuse can affect reproduction, and contribute to women's health problems as well as impair children's growth and development.[5] One of our studies,[6] analyzed reproductive hormone levels for 18 women ages 17 to 58. All were detoxified at screening, and had thorough physical examinations and laboratory tests. Two subgroups were identified.[20] Twelve women were diagnosed as alcohol dependent, and their alcohol intake ranged from about 1.5 to 11.0 ounces of absolute alcohol a day.[6] The other women were dependent on one or more drugs plus

alcohol.[4] Despite the fact that women in each group reported comparable numbers of male and female relatives, polysubstance dependent women also had at least one more alcohol dependent male relative.[4] The drug use patterns observed were diverse. Besides alcohol, ranging from 2.7 to 27.7 ounces of absolute alcohol a day,[6] cocaine was abused most frequently, followed by tranquilizers, sedatives, marijuana, opiates, and amphetamines. In keeping with their higher rates of alcohol consumption, polysubstance dependent women said they spent almost twice the amount of money a week on alcohol, averaging $49.70, as alcohol dependent women, averaging $25.30.[6]

Over 70% had abnormal hormone levels. Blood samples were obtained for analysis of the hormones essential for normal reproductive function in 18 women, namely luteinizing hormone, follicle stimulating hormone, prolactin, estradiol, and progesterone. Although all specific mechanisms of alcohol- and drug-induced disturbances of female reproductive hormones have yet to be determined, increased prolactin may promote amenorrhea, that is, prevent menstruation, or otherwise disrupt the menstrual cycle. Fifty percent of the alcoholic women had increased prolactin levels. One patient had amenorrhea with a normal prolactin level, but had low luteinizing hormone and estradiol levels. Two polysubstance dependent women had elevated prolactin, and one had amenorrhea with normal prolactin but low luteinizing hormone, follicle stimulating hormone, and estradiol levels.[6] It should be noted that 50% of the alcohol dependent women had no live births, but one polysubstance abuser reported 12 conceptions, resulting in one stillbirth, 5 spontaneous abortions, and 6 live births, with 2 of her teenaged children active substance abusers.[4]

Age was a strong factor in drug abuse patterns. There was a clear trend over the last two decades, whereby women both began substance abuse and risked pregnancy in their early teen years. Alcohol dependent women were much older at admission (average age 41.9 years) than polysubstance dependent women (26.8 years), and alcohol dependent women had been drinking regularly longer, averaging 17.2 versus 11.0 years. Alcohol dependent women also were significantly older when they first tried alcohol, average age 17.3 versus 12.3 years, and when they began regular alcohol use, average age 24.8 years versus 15.8 years. On average, alcohol

dependent women began sexual activity within a year of their 18th birthdays, while polysubstance dependent women reported that they had begun sexual activity shortly after age 15.[4]

Studies of Marijuana and Alcohol Effects in Healthy Women

We also examined marijuana and alcohol effects in women who were casual marijuana users or social drinkers with no known health problems, and no evidence of drug dependence. In addition to analysis of substance effects on reproductive functions studied under controlled laboratory conditions,[5, 21, 22] we systematically collected data on the marijuana and alcohol consumption from female marijuana smokers and alcohol and marijuana consumption from female social drinkers by means of daily questionnaires that recorded alcohol and drug intake, sexual activity, occurrence of unusual events, and changing mood states over time.[9, 13, 16, 23]

Effects of marijuana smoking on reproductive hormones in 16 women ages 21 to 33 were studied under laboratory conditions.[22] Each women smoked a one gram experimental marijuana cigarette. Blood samples for hormone level analysis were obtained for 92 hours before and 3 hours after smoking. Luteinizing hormone levels decreased an average of 30% when women smoked marijuana during the luteal phase of their menstrual cycles, that is, immediately after ovulation when the corpus luteum that sustains fertilized eggs (ova) should be developing. *Thus, marijuana decreased luteinizing hormone, which in turn may affect the fetus soon after conception.*[22]

Alcohol abuse is also associated with amenorrhea, anovulation, disruption of the luteal menstrual cycle phase, and damage to the ovaries, which can lead to infertility, spontaneous abortion, and early menopause.[5] One experiment [24] found that a dose equal to 2 drinks given to 12 female social drinkers during the follicular phase of the menstrual cycle affected their estradiol levels within 25 minutes after drinking, when blood alcohol levels were raised moderately. Increased estradiol in the early follicular phase may delay or prevent ovulation by suppressing follicle stimulating hormone, which is necessary to promote release of ova from the ovaries.

For some women as few as 3 drinks per day can affect their reproductive systems. An experiment that studied effects of daily alcohol consumption on 26 social drinkers [21] found that

there may be a cut-off point after which hormonal disruption occurs. About one-half of the women who had 3 or more drinks a day while living on a research ward also had increased prolactin levels or failed to ovulate.

Another of series of our studies examined *sociocultural, psychological, or biological factors that might promote or maintain smoking marijuana or drinking alcohol in women's normal environments*. In one study of *female marijuana smokers*, 30 women completed daily questionnaires for 3 consecutive menstrual cycles. Each day they recorded quantities and times of alcohol and marijuana use, episodes of sexual activity, and occurrence of unusual life events.[23]

Time factors significantly affected both marijuana and alcohol use. Division of these marijuana smokers into 2 consumption groups, 15 "heavy" users (about 3 cigarettes a day) and 15 "light" users (one or less cigarette a day), shows how adverse effects of polysubstance use may develop. Heavy users were significantly younger when they began to smoke marijuana. Heavy users also reported more alcohol use, more days of combined alcohol and marijuana use, greater frequency of morning marijuana smoking, and more days when they smoked marijuana morning, afternoon, and evening. *Most heavy marijuana users also smoked tobacco cigarettes, placing themselves at higher risk for pulmonary problems*. The 2 groups were similar in age at first alcohol use, age at first sexual intercourse, years of regular alcohol or marijuana use, years of education, and reported lifetime use of hallucinogens, tranquilizers, and cocaine.[23]

Study of 8 mood states recorded daily by these 30 women[13] also showed important differences between heavy and light users that could be factors which promote substance abuse. On days when they consumed *both alcohol and marijuana*, all women recorded stronger feelings of friendliness, vigor, and elation, but *when light users had both alcohol and marijuana they reported feeling less fatigued and tense*. Heavy users had lower scores for friendliness, elation, and vigor, and higher scores for tension, anger, fatigue, and confusion, so that, *being a heavy marijuana smoker influenced every mood but depression*. Unusual or stressful events occurred on 22% of all study days. Heavy users smoked marijuana more frequently on days when there were unusual events. *Women who reported unusual events also had stronger feelings of tension, confusion,*

anger, fatigue, and depression.[13] A study by Bruns and Geist[25] suggested that stress, both "good" and "bad" events, may differentially affect young men and women. Male and female high school students who used both alcohol and marijuana had similar numbers of stressful life events, but females generally reported a stronger response.[25] These data may partially explain contradictory findings regarding influences of stress in the onset of women's substance use.

Our study of 26 *female social drinkers* used a similar method whereby daily records of consumption patterns and events were collected for roughly 90 days. *Heavy drinkers*, averaging 1.80 or more drinks a day, *were much more likely to smoke marijuana, and to smoke more marijuana, than moderate drinkers*, averaging 1.75 or fewer drinks a day.[9] *Both frequent and occasional social drinkers said that drinking in groups increased their alcohol use.*[16]

Women Treated for Cocaine Dependence

A recent study[2] compared social characteristics, reasons for cocaine use, drug effects, depressive symptoms, and psychiatric diagnoses for 95 men and 34 women hospitalized in our treatment unit for cocaine abuse. More of the men were employed (78% versus 50%), and they tended to have professional, executive, and sales jobs. Women were younger than men at first drug use, about 15.6 versus 18.5 years old, younger at age of first substance abuse treatment, about 24.6 versus 29.1 years old, and had used cocaine for a shorter time, about 3.7 versus 5.4 years. Men and women were similar in total years of drug use--about 10.2 years, years of heavy drug use--about 5 years, number of different drugs used during the previous 30 days--about 4 drugs, and amount of cocaine used during the past 6 months--about 106.3 versus 107.5 grams; but men and women differed in the amount of money that they had spent on cocaine during the past 6 months--about $10,000 versus $3,000. More men were married (40% versus 21%), but more women lived with a drug dependent partner (36% versus 21%). *Thus, women were more likely to receive cocaine from men.*

Women gave 4 reasons for cocaine use: depression, feeling unsociable, family and job pressures, and health problems. Overall, men claimed more intoxication from cocaine, and men were more likely to say that cocaine decreased sexual feelings (67% versus 38%). Men and

women felt similar cocaine effects on aggression, appetite, anxiety, and mood, but women reported feeling less guilt. Most men and women (57%) said they used cocaine to feel sociable.[2]

The pattern of slower recovery from depression among female cocaine users makes their treatment more complex. More women had an Axis I DSM-III-R[20] diagnosis of depression. Women also had more depressive symptoms at admission and at 2 weeks and 4 weeks after admission.[2] Further, involvement with a drug-dependent partner may have contributed to the more rapid development of addiction in some women, since similar observations have been made for female heroin addicts[26] and alcoholics.[27]

Contributory Factors Reported From Other Studies

One important factor is the extent to which women who abuse alcohol and other drugs come from families that include other substance abusers,[4, 9] or live with spouses or mates who are substance abusers.[28] Follow-up data for 44 women were obtained approximately 6.5 years after alcohol treatment.[29] Exactly one-half recalled violence between their parents or between a parent and themselves, and 24 reported that one or both parents were alcoholic. At treatment, 80% had had at least one male partner, 57% had lived with an alcohol abuser, and 18% had violent partners.

Women who became abstainers changed their identities to nondrinkers by informing drinking partners that they wanted to abstain, by avoiding situations in which other people drank, by attending self-help groups, or through religious participation. Interestingly, even long-term abstainers relapsed into heavy drinking when prompted by a life crisis, such as divorce or removal of children from the household, although these factors could be consequences and not causes.

Another series of reports examined gender differences in addict careers[30, 31] for 546 male and female heroin users in methadone maintenance programs. *Women overall took less time to become addicted, and more women became addicted within a month. In comparison to men, significantly more women's heroin use was supported by others, and for a longer amount of time.* About 80% of men and women were married, and about 85% had lived with a sexual partner. About 15% of women recalled beginning drug use with a spouse or sexual partner who was a daily user, but no men said that their spouse or mate had initiated them into heroin use. Instead, men

were more likely to start use within a social group. No men reported living with a woman who was previously addicted, and women were more likely to be supplied with heroin than to supply others. Over 25% of the sample began daily heroin use within the first three weeks after initial use, and about 25% became dependent within a month of first heroin use. The average time from initiation into heroin use to dependence was shorter for women, 14 months, than for men, 21 months.

Comments

Women usually enter substance abuse treatment after significantly less time than men.[30, 31] *This pattern, called "telescoping," because of the more rapid development of serious substance abuse problems, also typifies women's cocaine use and alcohol abuse.* Accordingly, it is appropriate to conclude this brief review with the observation that substance abuse in many regards seems to be more serious for women. For the female substance abuser, the health and well-being of her children and herself are at serious risk. There is no single factor in women's experience that will prevent use or promote abstinence. Sociocultural, psychological and biological factors all combine and contribute to these problems, and sociocultural, psychological, and biological factors all must be addressed to relieve and prevent these problems.

ACKNOWLEDGEMENT

I am grateful to Carol Buchanan, who diligently prepared this manuscript.

REFERENCES

1. Lex BW. Gender differences and substance abuse. In: Advances in Substance Abuse: Behavioral and Biological Research. Greenwich, CT: JAI Press, in press, 1990.
2. Griffin ML, Weiss RD, Mirin SM, et al. A comparison of male and female cocaine abusers. Arch Gen Psychiatry 1989; 46:122-126.
3. Mello NK. Etiological theories of alcoholism. In: Advances in Substance Abuse: Behavioral and Biological Research. Greenwich, CT: JAI Press, 1983.
4. Lex BW, Teoh SK, Lagomasino I, et al. Characteristics of women receiving mandated treatment for alcohol or polysubstance dependence in Massachusetts. Drug Alcohol Depend 1990; 25:13-20.
5. Mello NK, Mendelson JH, Teoh SK. Neuroendocrine consequences of alcohol abuse in women. Ann NY Acad Sci 1989; 562:211-240.
6. Teoh SK, Lex BW, Coulter J, et al. Anterior pituitary gonadal and adrenal hormones in women with alcohol and polydrug abuse. Presented at 60th Anniversary Fifty-First Annual Scientific Meeting Abstracts, Keystone, CO: The Committee on Problems of Drug Dependence, Inc., 1989.
7. Russell M, Henderson C, Blume SB. Children of Alcoholics: A Review of the Literature. New York: Children of Alcoholics Foundation, 1985.
8. Midanik L. Familial alcoholism and problem drinking in a national drinking practices survey. Addict Behav 1983; 8:133-141.
9. Lex BW, Lukas SE, Greenwald NE, et al. Alcohol-induced changes in body sway in women at risk for alcoholism: A pilot study. J Stud Alcohol 1988; 49:346-356.
10. Schuckit MA. Subjective responses to alcohol in sons of alcoholics and control subjects. Arch Gen Psychiatry 1984; 42:879-884.
11. Clayton RL, Voss HL, Robbins C, et al. Gender differences in drug use: An epidemiological perspective. In: Women and Drugs: A New Era for Research. NIDA Research Monograph 65. Washington, D.C.: U.S. Government Printing Office, 1986.
12. Mello NK. A behavioral analysis of the reinforcing properties of alcohol and other drugs in man. In: The Pathogenesis of Alcoholism, Biological Factors. New York: Plenum, 1983.
13. Lex BW, Griffin ML, Mello NK, et al. Alcohol, marijuana, and mood states in young women. Int J Addictions 1989; 24:405-424.
14. Birnbaum LM, Taylor TH, Parker ES. Alcohol and other mood state in female social drinkers. Alc Clin Exp Res 1983; 7:362-368.
15. Gilligan C. In a Different Voice. Cambridge: Harvard University Press, 1982.
16. Lex BW. Reasons for alcohol use by female heavy, moderate, and occasional social drinkers. Alcohol 1989; 6:281-287.
17. Ferrence R, Whitehead P. Sex differences in psychoactive drug use: Recent epidemiology. In: Alcohol and Drug Problems in Women, Vol 5, Research Advances and Drug Problems. New York: Plenum Press, 1980.

18. National Institute on Drug Abuse, eds. National Household Survey on Drug Abuse: 1988 Cross-Sectional Data. U.S. Department of Health and Human Services, 1989.

19. Lex BW. Alcohol problems in special populations. In: The Diagnosis and Treatment of Alcoholism. New York: McGraw-Hill, 1985.

20. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. Third edition. Washington, DC: Author, 1987.

21. Mendelson J, Mello N. Chronic alcohol effects on anterior pituitary and ovarian hormones in healthy women. J Pharmacol Exp Ther 1988; 245:407-412.

22. Mendelson J, Mello NK, Ellingboe J., et al. Marijuana smoking suppresses luteinizing hormone in women. J Pharmacol Exp Ther 1986; 237:862-866.

23. Lex BW, Griffin ML, Mello NK, et al. Concordant alcohol and marihuana use in women. Alcohol 1986; 3:193-200.

24. Mendelson J, Lukas S, Mello N, et al. Acute alcohol effects on plasma estradiol levels in women. Psychopharmacology 1988; 94:464-467.

25. Bruns C, Geist C. Stressful life events and drug use among adolescents. J Human Stress 1984; 10:135-139.

26. Kosten TR, Rounsaville BJ, Kleber HD. Ethnic and gender differences among opiate addicts. Int J Addictions 1986; 20:1143-1162.

27. Hesselbrock MN, Meyer RE, Keener JJ. Psychopathology in hospitalized alcoholics. Arch Gen Psychiatry 1985; 42:1050-1055.

28. Robbins C. Sex differences in psychosocial consequences of alcohol and drug abuse. J Hlth Social Behav 1989; 30:117-130.

29. Haver B. Female alcoholics: III. Patterns of consumption 3-10 years after treatment. Acta Psychiat Scand 1987; 75:397-404.

30. Anglin MD, Hser YI, McGlothlin WH. Sex differences in addict careers. 2. Becoming addicted. Am J Drug Alcohol Abuse 1987; 13:59-71.

31. Hser YI, Anglin MD, Booth MW. Sex differences in addict careers. 3. Addiction. Am J Drug Alcohol Abuse 1987; 13:231-251.

PREPARED STATEMENT OF DR. TREVOR LIPSCOMBE, RESEARCH COORDINATOR, COVENANT HOUSE (ADVOCACY), NEW YORK, NY

Covenant House is a private non-profit organization which annually cares for over 25,000 runaway and homeless youth under the age of 21 in the United States. As substantial numbers are pregnant or parenting women, and given that substance abuse is an unfortunate scourge of life on the streets, we respectfully submit this testimony to the Select Committee on Children, Youth and Families with regard to emphasising the difficult problems currently faced by addicted women.

Street kids are not easily classified, except that they are neither Huck Finns nor Becky Sharps. They often have deep-rooted psychological problems, sometimes stemming from physical or sexual abuse by a family member. They seldom have graduated from high school, and their low level of literacy makes it difficult for them to get any but the most menial of jobs.

Running from an unsafe, violent family situation leaves them on the street with little or no resources. Some will find their way to a shelter such as Covenant House; the rest have to survive as best they can, flirting with crime, and selling drugs and their bodies.

Substance abuse is a recurring theme throughout the lives of these young people. From under-age drinking and smoking -- which no-one really seems to object to, although

such activities are illegal in the fifty states -- to smoking crack, a viciously addictive form of cocaine which has brought the price of hard drugs down to an affordable level for street kids, drugs have always been present in their lives to ease the tension and numb the pain of existence. Sex is also there, a desperate cry for attention and affection, however brief may be the relationship from which it stems. It is not surprising that the pregnancy rate for homeless girls is high, or that many of them chose to keep their babies; in many cases the baby is the first human being who has responded to them with love and who needs them.

These are the kids to whom Covenant House seeks to throw a lifeline. We urge the Federal government to do likewise. We applaud the committee's openness in listening to many different aspects of substance abuse, and we urge the members to take swift and incisive action before we lose another generation of young people through addiction.

We have established mother-child programs at each of the Covenant House sites. In 1989, these programs cared for over 3000 women and their children. Covenant House provides pre-natal care for those who are pregnant, all the supplies they need, such as baby food, pampers and baby clothes and even arranges child care for young women who are looking for employment. We also provide parenting classes, so that they

possess the parenting skills to match the love they have for their babies. The aim is that when these young families leave Covenant House, they will be independent and have an alternative to a life on welfare.

At our New York site, the mother-child unit now employs two substance-abuse counselors. They hold substance-abuse education classes to prevent the residents from becoming involved in substance abuse, carry out drug assessments to determine whether a resident has a substance-abuse problem, and try to obtain residential treatment placements for those young mothers who require them. These placements are far to hard to come by. Since January 1, 1990, the counselors have conducted 86 assessments; 23 percent of the women are diagnosed as having a substance-abuse problem and an additional 47 percent are in the "high risk" category. The counselors have now abandoned their attempts to place these mothers and their children is residential treatment centers, since the wait for such a placement in New York City is about 4-6 months. Instead, day treatment facilities are used and the family remains in residence at Covenant House.

The massive increase in substance abuse levels that has occurred among homeless youth is not limited solely to pregnant or parenting women. It started in about 1985, with the advent of crack cocaine, and has now reached epidemic proportion. A survey undertaken at Covenant House

New York showed that 40 percent of residents voluntarily report substance abuse as a problem. In our Re-entry program, which facilitates return visits to Covenant House by the hard-core street kids who find it difficult to remain in a shelter environment, the level is 58 percent.

Our agency responded to this by establishing the Covenant House Addiction Management Program (CHAMP). It is a unique program which helps homeless youths deals with addiction problems, whether their drug of choice be crack, heroine, marijuana or alcohol. It combines the twelve-step program employed by Alcoholics Anonymous, with individual and group counseling sessions. It is especially important for teenagers to have group sessions, since traditionally adolescents rely much more on peer support and respond better to peer pressure than they do to the input of authority figures. This is particularly true of street kids, who in the past have often dismissed authority figures, such as parents and teachers, out of hand.

The sad fact is, however, that young parenting or pregnant women are just as prone to substance abuse as all other homeless youth. Interviews with over 1100 residents undertaken by health services professionals at our Fort Lauderdale site revealed that:

1. 75.5% of youths have tried an illegal drug at some

time. 36% say they have used drugs within the last month, and 18% admit they use drugs daily.

2. Although prevalence levels are lower for women than men, over 20% of women have smoked marijuana within the last month, and over 12% have used crack or cocaine.

3. Disturbingly, pregnant or parenting women use drugs just as often, and if not more frequently than the other women who are not. Within the month prior to the interview, 19% of pregnant/parenting women had smoked marijuana, just under 18% had used either crack or cocaine and 34% had drunk alcohol.

4. Only 18% of parenting women had sought treatment, as opposed to 23% of all the residents questioned, a significant difference. It may be that fear of having to give up their baby deters these young mothers from seeking help.

5. Interestingly, the only category in which prevalence levels are reduced for pregnant or parenting women is cigarette smoking (42% as opposed to 55%). This may be a response to the clear warnings that cigarette smoking during pregnancy can harm your children.

6. A nurse diagnosed over 37% of pregnant or parenting women as having a substance abuse problem. Of these, under half (48%) said they wanted help.

In spite of the evident need for residential treatment programs for pregnant or parenting women, there is a dearth of such places. Most programs, a survey in New York City found out, do not admit this category of substance abuser. Society is then presented with the tragedy of young mothers who want to get help and are not able to receive it. They are at risk of having their children taken into foster care, with all the emotional distress that such action could incur.

Thus we have pregnant women, desperately seeking help, and having to face the prospects that they are more likely to have a baby who is underweight, premature and has a tendency to hyperactivity, or else is miscarried or stillborn, despite their efforts to obtain treatment.

Society has a price to pay for neglecting the needs of these women. First, substance abusing mothers often have to relinquish their children at least temporarily to social service agencies. As the number of "cocaine babies" grows, the need for a dramatic increase in foster care will rise subsequently. For women receiving Medicaid, the government

must foot the bill if their children have to receive intensive care in a neo-natal unit which, as was outlined above, is quite possible. Finally, if the parental bond is weakened by substance abuse, we have the grim specter of an increase in juvenile delinquency and, most probably, a generation raised thinking that drug use is acceptable.

Some prosecutors have already acted out of frustration; in response to the seemingly unstoppable tidal wave of substance abuse among mothers, they have responded by placing some pregnant women in prison. The intention of incarceration is to force more women with drug problems to seek help. There is, however, an alternative way to approach the problem.

Pregnant or parenting women with drug problems face a dilemma. Due to the lack of placements, the only way they can currently receive help is to place their child in foster care or with a family member. The chances of regaining custody of the child may not be that high if one has to admit to a recent substance-abuse problem.

By dramatically increasing the number of available beds, the government can allow these women to fulfil their two main desires: to keep their babies with them, and to get treatment. Currently these two desires are almost mutually

exclusive, and the women opt for retaining their children as opposed to seeking help.

Given those circumstances, it is imperative that funds be appropriated to expand substantially the number of drug treatment placements for pregnant and parenting women Appropriations should be made to create new facilities, expand existing ones and contorl the quality of the services. The appropriations should also include funds for advertising, on TV, radio, inner-city billboards and public transit. The message:

"You don't have to give up your baby to get help with your drug problem."

An alternative would be to give women in their child-bearing years priority access to the existing treatment slots. This is the initiative of the Maryland State Legislature. It would make much sense, of course, to help women overcome their problems even before they become pregnant, and Maryland's plan is definitely a step in that direction.

Finally, all such programs should incorporate parenting skills seminars. A survey at Odyssey House, one of the few programs in New York City which provides residential services for young mothers and their children, shows a success rate of 68 percent for young parents, almost 30

percent higher than the rest of the population. It is the strength of the parent-child bond that works in their favor, and the stronger that bond can become by parenting skill programs, the greater the chance of success.

Availability of day care for children also can enhance a mother's potential for resisting or combatting substance abuse. The mother then can find employment, which improves her self-image, enables her to take care financially of her children and also broadens her horizons, reducing her inclination toward substance abuse.

We wish to thank you for thoughtful consideration of this testimony, and trust that you will act swiftly to help these young mothers and their children, who are all victims of society's neglect.

PREPARED STATEMENT OF FARROKH SHAHRIVAR, M.D., ASSOCIATE DIRECTOR OF PEDIATRICS, CHIEF/NEONATOLOGY DIVISION, ST. LUKE'S-ROOSEVELT HOSPITAL CENTER, NEW YORK, NY

My name is Farrokh Shahriver. I am a board certified pediatrician with a sub-board certification in neonatal-perinatal medicine. I am the Associate Director of Pediatrics and Chief of the Neonatology Division of the St. Luke's-Roosevelt Hospital Center ("SLRHC"). Thank you for your invitation to submit testimony for the record in your hearing on women, addiction and perinatal care. As Chief of the SLRHC Neonatology Division, I am all too familiar with the toll drugs -- particularly crack -- has taken on the mothers, children and families served by SLRHC.

St. Luke's-Roosevelt Hospital Center is a voluntary hospital affiliated with Columbia University College of Physicians and Surgeons. The Hospital's service area extends along Manhattan's West Side from 34th Street to 142nd Street and includes within it areas with extremely high rates of adverse birth outcomes. While the role of poverty cannot be ignored, when crack enters the picture the magnitude of the problem is staggering.

In 1989, SLRHC performed approximately 4,800 deliveries. Six hundred babies were admitted to the Hospital's Neonatal Intensive Care Unit; approximately 25 percent of those admissions (150 babies) were born to drug-abusing mothers. Drug-exposed infants demonstrate a greater need for neonatal intensive care services because of their higher incidence of low birthweight and prematurity.

The Hospital uses the following criteria to determine which mothers/infants should have a urine toxicology test to determine the presence of drugs: all mothers not registered at SLRHC for prenatal care; mothers with signs of drug abuse; a maternal history of drug abuse; signs of withdrawal syndrome in infant; abnormal maternal behavior reported by nurse, physician

or social worker. Using these guidelines in 1989, SLRHC detected drugs in 275 infants; in all but five of the infants, the drug was cocaine (crack).

While the numbers are bad and getting worse, the numbers only begin to tell the tragedy. Thirty-five percent of infants born to substance-abusing mothers are premature with birthweights ranging from a high of 6 pounds to a low of 1 pound. A few are born outside the Hospital -- on the street, in cars and at home under horrible conditions. Our paramedics rescued one infant from the toilet bowl.

The mothers are difficult to work with, more difficult to treat. One patient was so drugged that she could not push effectively during labor. As a result a caesarian section was performed. Another woman refused to remove her stockings in the labor and delivery room. It turned out that she was hiding cocaine in her stockings.

Some women walk in without labor pain with fetal demise. The "lucky" infants who survive the 4-5 month intensive care stay find themselves without parents or a home. They remain in the Hospital as "boarder babies" until an appropriate placement can be found. In 1986, the Hospital had 167 boarder babies. By 1989, the figure had almost doubled to 315. Fifty-seven percent of boarder babies are eventually discharged into foster care; 21 percent to the mother's care; 20 percent to another relative and, 2 percent to the father.

The numbers make abundantly clear what crack is doing to the families in our community. Let me spend a few minutes describing crack's effect on the physical health of these mothers and infants. These mothers have high rates of syphilis, TB and positive HIV, also high blood pressure, tachycardia and arrhthymia. Crack may cause malformation in

the fetus and in some instances death. In 1989, this Hospital had 47 stillborns; 19 of these were directly attributable to maternal substance abuse (crack). In the newborn we see jitteriness and irritability, feeding problems and sleep disorders. Necrotizing entrocolitis (inflammation and perforation of the intestinal tract) occurred more than twice as frequently in the cocaine-positive group (7.3 percent of cocaine-positive infants versus 3.4 percent of cocaine-negative infants). These infants are also at increased risk of Sudden Infant Death Syndrome and neurological impairment, including short attention span and problems with fine motor coordination.

You have asked for my recommendation on solutions to this growing problem. My initial response is not new or original -- but it is compelling. We must provide comprehensive prenatal and substance abuse services to at-risk women. The programs must be community-based with extensive, culturally sensitive outreach. The drug treatment programs should be non-punitive. These neighborhood programs should be part of a tight network for referrals to regional hospitals for evaluation and delivery.

There are too few comprehensive programs. Of the few that exist, some target pregnant women; others target substance abusers. And only a handful work with pregnant substance abusers.

After delivery, we need special parenting programs with home services to develop maternal competence and a positive relationship with her infant which leads to stabilized families. Drug treatment programs remain key. In addition, we need special day care centers where children can receive comprehensive health care addressed to their special needs and where their mothers are helped to find lives away from the drug culture which threatens their lives and the lives of their offspring.

Today there are 23 babies in the Neonatal Intensive Care Unit at SLRMC. That puts it at 153 percent of capacity. The nurses and doctors struggle to keep each and every one of these babies alive. Despite our best efforts, a few will die and more will be subject to life-long disabilities. A short visit to this unit makes my point: early prenatal care, coupled with substance abuse services, is absolutely critical. We have the will; we need the resources.

Thank you.

PREPARED STATEMENT OF DR. HERBERT D. KLEBER, DEPUTY DIRECTOR FOR DEMAND REDUCTION, OFFICE OF NATIONAL DRUG CONTROL POLICY, EXECUTIVE OFFICE OF THE PRESIDENT, WASHINGTON, DC

I have been working in the field of drug abuse for nearly twenty-five years, and no single phenomenon has demonstrated to me the destructive power of drugs as vividly as babies who have been exposed to crack and other drugs before birth. Government and private sector leaders must work together to find careful and rational approaches to this problem.

During the past decades, the vast majority of users of illicit drugs in America have been men. In 1985, crack cocaine somewhat altered that pattern. Even though the rate of cocaine use is still twice as high for men than for women, there are now unprecedented numbers of female addicts, many of whom are pregnant or are of childbearing age.

Unfortunately, one of the most fundamental questions concerning this issue is not readily answered, the question of how many "crack babies" there actually are. The first obstacle to finding an answer is confusion as to what we mean by "crack baby." We know that all babies who are exposed to drugs, including crack, do not suffer equally. Some are, in fact, born addicted to cocaine, and are found to have smaller head circumference, low birth weight, severe brain damage, and because of withdrawal, cannot be touched or held during the days following delivery.

Other children, who are sometimes referred to as "crack babies," have been exposed to cocaine or other drugs in utero, but are not, in fact, born addicted or significantly impaired. However, they may later suffer problems such as attention deficit disorder and other learning disabilities. Surprisingly, some drug-exposed babies escape physical and mental harm.

The available data leaves much to be desired, and there remain great differences among estimates of the prevalence of this problem. Some experts have estimated that there are at least 30,000, and others as many as 375,000 babies who have been born addicted to, or severely impaired by, drugs.

Determining accurately the depth and breadth of the problem is important, and both the National Institute on Drug Abuse and the Centers for Disease Control have undertaken surveys which will give us a much better idea what we are up against. Regardless of the number, there are too many of these babies, and finding solutions to their plight, albeit difficult, is a priority in the President's National Strategy.

The challenge before us is three-fold. First, female addicts, especially those who are pregnant, must be pushed and helped to stop their behavior which is destructive to themselves and to the children they may be carrying. Second, children who have already

been brought into this world severely handicapped by their mothers' use of drugs need special attention and the care of loving hands. Third, we must prevent further drug use, and the addiction that follows, by all members of society -- including women of childbearing age. It is clear our society can neither afford nor manage large numbers of "crack babies."

This particular aspect of the anti-drug effort must be solved, ultimately, through a mix of supply and demand reduction activities. The criminal justice system, drug treatment, and drug prevention efforts must all be brought to bear in unprecedented cooperation if we are to make a difference.

The President's National Strategy contains concrete proposals to increase all these efforts. In particular, we are seeking to increase treatment capacity and markedly improve the effectiveness of the Nation's drug treatment system. Federal, State, and local authorities are working steadfastly to expand the availability of treatment, especially for priority populations such as pregnant addicts. The President's budget request would provide 68% more Federal money for treatment than was available when he took office. These new funds will begin to bring the supply of publicly-funded treatment more in line with the number of addicts who need it. I would hope that the States will follow the Federal lead and expand their own support for drug treatment, especially for pregnant addicts.

Unfortunately, pregnant addicts are often among the most reluctant to seek treatment, and many treatment programs are not equipped to accept them. Pregnant addicts in the custody of the criminal justice system can sometimes be required to remain in residential treatment until after they deliver. But outreach efforts are needed for other pregnant addicts, who must willingly enter and remain in treatment programs providing pre-natal and post-partum care for them and their children.

With the goal of finding solutions to these complicated problems, the National Strategy calls for significant additional resources for pregnant addicts and their children not just in treatment, but in outreach and research initiatives as well. Through State treatment action plans proposed by the President, States will be held accountable for providing improved and expanded outreach efforts and treatment programs for pregnant addicts. The Office of Substance Abuse Prevention (OSAP) will award grants in Fiscal Year 1991 to support demonstration programs on prevention, education, and early intervention. The National Institute on Drug Abuse (NIDA) will make funds available for Fiscal Year 1991 demonstration grants for research and development of outreach as well as safe and efficacious treatment services to pregnant addicts and their children.

As an aside, let me say that Congress' failure last session to

enact the President's amendment related to Statewide Treatment Action Plans was a great disappointment to me. These plans would instill accountability into the Nation's treatment system and would provide crucial information not just in the area of drug-exposed babies, but across a wide range of treatment issues. I know that both chambers resoundingly passed this amendment, and yet it became tied up in conference committee due to other issues. Congress has appropriated significant resources to drug treatment in recent budgets. The amendment would help ensure that funds are spent on the most effective programs.

As a clinician and scientist, I am optimistic about increased efforts by NIDA to learn how drugs taken by the mother affect intrauterine development and how babies born to addicted mothers can best be treated. For example, medication that could block the effects of drugs or decrease craving for them without harm to the fetus would be extremely valuable in treating pregnant addicts. Pioneering work is being initiated to develop treatment agents that would not pass through the placenta to harm the unborn child, and to develop treatments that could alleviate the effects of drugs on newborn infants.

These are just some of the ways in which the National Strategy proposes we address the complicated and serious problem of drug-affected children. It is also important for us to realize that this problem is but the most serious manifestation of the broad

devastation drugs have brought to our country. We will be no more successful helping pregnant addicts and their offspring than we are in reducing drug consumption across the board.

We can and should take heart from scattered indications that the Nation's current cocaine epidemic is no longer spiralling out of control and may be levelling off. But we cannot and will not let up. There is much more that remains to be done. I look forward to working with you and your colleagues in the weeks and months ahead.

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
[illegible]
WASHINGTON, DC 20515

May 7, 1990

Sheila B. Blume, M.D.
Medical Director
Alcoholism, Chemical Dependency and
Compulsive Gambling Services
South Oaks Hospital
Amityville, NY 11701

Dr. Blume:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Beyond the Stereotypes: Women, Addiction and Perinatal Substance Abuse," held here in Washington, April 19. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by May 18 with any necessary corrections.

In addition, I am requesting that you respond in writing to the following questions so that they may be included in the hearing record:

1. You submitted materials about dual diagnosis. Why is it important to make dual diagnoses? Is one of the diagnoses likely to be overlooked? What should happen next when such a diagnosis is made?

2. What factors do you believe have contributed to the recent increase in heavy drinking among women?

3. Do you have any suggestions about what financial or organizational incentives to the health care system for screening for alcoholism should look like?

4. Are there special confidentiality problems in screening pregnant women? How would you make sure that such a procedure wouldn't frighten women away from care?

5. Isn't there a good chance that cases would be missed by a physiological screen? Are there other procedures that should be employed in addition to or instead of the physiological screen?

6. Do we know anything about mortality or death rates associated with alcohol abuse in women?

7. You say that the 10% women's treatment set aside in the Alcohol, Drug Abuse, and Mental Health Block Grant has been studied, and that the effect of this policy was good. Who did the study, and can you be more specific about what they found?

8. You said that use of the 10% set aside was left up to the states, and that it was not being used as well as it could be. You recommended putting "teeth" in the legislation. Can you be more specific about these comments, and suggest some accountability mechanisms that state and local providers could benefit from?

Let me again express my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

SOUTH OAKS HOSPITAL
The Long Island Home, Ltd.
400 Sunrise Highway, Amityville, L.I., New York 11701
(516) 264-4000
FAX: (516) 598-1364
Established 1882

Leonard W. Krinsky, Ph.D., *Executive Director*
Chester J. Omiecinski, *Administrator*
Sophi Surmeli, M.D., *Clinical Director*

May 15, 1990

Chairman George Miller
Select Committee on Children,
Youth, and Families
385 House Office Building Annex 2
Washington, DC 20515

Dear Chairman Miller:

I enclose the edited transcript of my testimony and written replies to your additional questions. In addition, I have attached copies of the Health Questionnaire, a screening tool to identify alcohol and drug problems in women, and the National Council on Alcoholism and Drug Dependence report on the women's set aside program.

I am aware that the next hearings on this subject will focus on public policy initiatives. It has been my goal for many years to help develop a systematic routine screening for chemical dependency in obstetric practices, as the most realistic and practical way to prevent serious birth defects. Demonstration projects will only be effective if they are followed by a mechanism to make them universally available. I hope that your Committee will help make this dream a reality. Please feel free to call on me for any assistance I can provide.

Yours sincerely,

Sheila Blume

Sheila B. Blume, M.D.
Medical Director
Alcoholism, Chemical Dependency
and Compulsive Gambling Programs

SBB/bc
enclosure

Response to Questions Posed by Chairman George Miller

1. Why is it important to make dual diagnoses? Is one of the diagnoses likely to be overlooked? What should happen next when such a diagnosis is made?

An understanding of the patient's entire range of problems is necessary for adequate treatment planning. If important disorders are overlooked, recovering from chemical dependency is unlikely. The most common dual diagnosis is different among women compared to men. Among men with addictive disorders anti-social personality is the most commonly associated psychiatric disorder. In women, major depression is the most common. Furthermore, in two-thirds of the cases, major depression was present before the onset of alcohol abuse or dependence among women with these two diagnoses. Women in this latter category are at risk for recurrent depression. If the recurrence of depression can be identified and treated immediately, the patient's recovery from chemical dependency will continue. If the depression is not treated she is likely to relapse into alcohol and/or drug use.

2. What factors do you believe have contributed to the recent increase in heavy drinking among women?

I believe the intense advertising and marketing of alcoholic beverages is one of the major factors contributing to increasing alcohol use among young women. Women and young people have been targeted as a growth market by the alcoholic beverage industry. Marketing on campuses and in minority communities is intense. I think that meaningful health warnings (ones that do not require a microscope to see) and controls on advertising and marketing would help.

3. Do you have any suggestions about what financial or organizational incentives to the health care system for screening for alcoholism should look like?

There are now a few model programs funded by OSAP already in place. Those programs that are the most cost-effective, that is, require the least additional expense to accomplish the goal of identification, intervention and referral, could be replicated throughout the country through a program of Federal financial initiatives. At the same time, those bodies that certify and accredit hospitals and health care training programs could add to their requirements that every obstetrical service have a screening, referral and follow-up system in place for helping chemically dependent pregnant women.

4. Are there special confidentiality problems in screening pregnant women? How would you make sure that such a procedure wouldn't frighten women away from care?

Any systematic routine screening for alcohol and drug problems in pregnancy generates, by its nature, problems in confidentiality. If alcohol and/or drug testing of the pregnant woman or her newborn is used for therapeutic purposes (intervention, treatment planning, follow-up monitoring, etc.) it will benefit both mother and child. If the same testing is used to initiate criminal or civil action against the woman in question, the process will act as an additional barrier to treatment, deterring women in need from seeking both obstetric and chemical dependency treatment. Assemblywoman Gloria Davis, in the New York State Assembly, has proposed legislation that would prohibit the use of such perinatal chemical testing in the health care system for other than medical purposes. This legal principle should be generally accepted. In no case should the results of a chemical test alone result in punitive action against a woman. If a child needs to be removed from the home, evidence of child abuse or neglect should be required - not the results of a urine test alone.

Another potential problem would be the designation of alcohol or drug use during pregnancy as "prenatal child abuse,"

with a requirement for reporting any knowledge or suspicion of such use to the State Child Protection Agency. Mandating such reports would further erode the doctor/patient relationship and discourage treatment. Any woman who reads the newspapers or watches television is aware of instances of women being arrested and prosecuted from maternity wards. Such events do not encourage trust in the health care system on the part of these women. If women are advised that their treatment for chemical dependence will be reported for State investigation if they should become pregnant, it will drive them away.

5. Isn't there a good chance that cases would be missed by a physiological screen? Are there other procedures that should be employed in addition to or instead of the physiological screen?

I have attached a copy of the Health Questionnaire designed by Dr. Marcia Russell of the Research Institute on Alcoholism in Buffalo, New York. This questionnaire is very helpful in identifying potential alcohol or drug problems in medical practices, especially in women. Another good source of information is an interview with the patient's family. These methods can supplement physiological tests. In addition, Dr. Robert J. Sokol and his colleagues have developed a simple, 4-question screening test known as T-ACE. A score of 2 points

indicates the need for an assessment (Reference - American Journal of Obstetrics and Gynecology, Vol. 160 #4, pp. 863-870, April, 1989).

6. Do we know anything about mortality or death rates associated with alcohol abuse in women?

Alcoholism is a deadly disease for women. Two recent studies have demonstrated high mortality rates. Dr. Elizabeth Smith of Washington University in St. Louis found the mortality rate 4.5 times above the expected rate in a group of 103 alcoholic women following treatment. They lost an average of 15 years from their expected lifespan. An additional study from Stockholm looked at death rates for nearly 5,000 alcoholics treated over a 20 year period. For men the mortality rate was 3 times higher than expected. For women it was 5.2 times the expected age-corrected rate.

7. You say that the 10% women's treatment set aside in the Alcohol, Drug Abuse, and Mental Health Block Grant has been studied, and that the effect of this policy was good. Who did the study, and can you be more specific about what they found?

The evaluation of the effectiveness of the women's set-aside was performed by the National Council on Alcoholism. A report entitled "A Federal Response to a Hidden Epidemic: Alcohol and Other Drug Problems Among Women" was published by NCA in 1987. It showed a substantial increase in treatment availability related directly to the set aside legislation.

31-228 0 - 90 - 7

[The report from the National Council on Alcoholism entitled "A Federal Response to a Hidden Epidemic: Alcohol & other Drug Problems Among Women" is retained in committee Files].

8. You said that use of the 10% set aside was left up to the states, and that it was not being used as well as it could be. You recommended putting "teeth" in the legislation. Can you be more specific about these comments, and suggest some accountability mechanisms that state and local providers could benefit from?

The women's set aside could be used more effectively if the states were required to use the money for direct funding of women's programs and for the monitoring of such programs. The states should be asked to prioritize their unmet needs for women, fund programs directly with this money, and monitor these programs. They should be required to report back to ADAMHA on the prioritization process and the use of the funds. At the beginning of my term as New York State Commissioner (1979) every state was required to produced an annual plan which reflected our use of Federal funds for alcoholism programming. The requirement for this plan was dropped when the block grant mechanism was adopted. An annual plan could be reinstituted to cover the use of special funds targeted to under-served populations in need of chemical dependence services.

HEALTH QUESTIONNAIRE

Please check answers below.

1. When you are depressed or nervous, do you find any of the following helpful to feel better or to relax?	Very Helpful	Not Helpful	Never Tried
a. Smoking cigarettes	____	____	____
b. Working harder than usual at home or job	____	____	____
c. Taking a tranquilizer	____	____	____
d. Taking some other kind of pill or medication	____	____	____
e. Having a drink	____	____	____
f. Talking it over with friends or relatives	____	____	____

2. Think of the times you have been most depressed; at those times did you:	Yes	No
a. Lose or gain weight	____	____
b. Lose interest in things that usually interest you	____	____
c. Have spells when you couldn't seem to stop crying	____	____
d. Suffer from insomnia	____	____

3. Have you ever gone to a doctor, psychologist, social worker, counselor or clergyman for help with an emotional problem?	____	____

4. How many cigarettes a day do you smoke? Check one.

____ More than 2 packs ____1-2 packs ____Less than 1 pack ____None

5. How often do you have a drink of wine, beer, or a beverage containing alcohol?

____3 or more times a day ____Once or twice a week

____Twice a day ____Once or twice a month

____Almost every day ____Less than once a month ____Never

6. a. If you drink wine, beer or beverages containing alcohol, how often do you have four or more drinks?

____Almost always ____Frequently ____Sometimes ____Never

b. If you drink wine, beer or beverages containing alcohol, how often do you have one or two?

____Almost always ____Frequently ____Sometimes ____Never

7. What prescribed medications do you take? _____

8. What other drugs or medications do you use? _____

	Yes	No
9. Does your drinking or taking other drugs sometimes lead to problems between you and your family, that is, wife, husband, children, parent, or close relative?	____	____
10. During the past year, have close relatives or friends worried or complained about your drinking or taking other drugs?	____	____
11. Has a friend or family member every told you about things you said or did while you were drinking or using other drugs that you do not remember?	____	____
12. Have you, within the past year, started to drink alcohol and found it difficult to stop before becoming intoxicated?	____	____
13. Has your father or mother ever had problems with alcohol or other drugs?	____	____

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515

May 7, 1990

Alan Trachtenberg, M.D., M.P.H.
Medical Director
Bay Area Addiction, Research and Treatment
45 Franklin St., Suite M
San Francisco, CA 94102

Dr. Trachtenberg:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Beyond the Stereotypes: Women, Addiction and Perinatal Substance Abuse," held here in Washington, April 19. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by May 18 with any necessary corrections.

In addition, I am requesting that you respond in writing to the following question so that they may be included in the hearing record:

> Could you expand a little on the Governor's plan to eliminate MediCal reimbursement for heroin detoxification? How does he propose to make it possible for low-income opiate addicts to obtain detoxification? What is the restriction on reimbursement for cocaine addiction under MediCal? What kind of burden does such restriction place on addicted, pregnant women?

Let me again express my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families
Enclosure

RESPONSE TO QUESTION POSED BY CHAIRMAN GEORGE MILLER

BAART
COMPREHENSIVE HEALTH CARE & EDUCATIONAL SERVICES
Administrative Office
45 Franklin Street
Suite 2 North
San Francisco, CA 94102
(415) 552-7914

BAY AREA REGION

Geary Street Clinic
1040 Geary Street
San Francisco, CA
94109
(415) 928-7800

Embarcadero Clinic
75 Townsend Street
San Francisco, CA
94107
(415) 543-2656

FACET
Family Addiction Center
for Education & Treatment
1040 Geary Street
San Francisco, CA
94109
(415) 928-7800

FRESNO REGION

South Orange Clinic
2651 South Orange
Fresno, CA
93725
(209) 268-6251

Van Ness Clinic
539 North Van Ness
Fresno, CA
93728
(209) 266-9561

LOS ANGELES REGION

Southeast Clinic
4920 S. Avalon Blvd
Los Angeles, CA
90011
(213) 235-5035

West Hollywood Clinic
8512 W. Whitworth Ave
Los Angeles, CA
90035
(213) 657-6046

El Monte Clinic
3225 N. Tyler Ave
El Monte, CA
91731
(818) 442-4411

Olympic Clinic
1020 W. Olympic Blvd
Los Angeles, CA
90015
(213) 747-2267

CONTRA COSTA REGION

Pittsburg Clinic
45 Civic Avenue
Pittsburg, CA
94565
(415) 427-2265

Richmond Clinic
2910 Cutting Blvd
Richmond, CA
94804
(415) 232-0874

May 24, 1990

The Honorable George Miller
Chair, Select Committee on Children,
Youth & Families
385 House Office Building Annex 2
Washington, D.C. 20515

RE: Governor's Proposal to Remove Heroin Detoxification Services as a Medi-Cal Benefit

Dear Representative Miller:

Thank you for your inquiry regarding the current proposal to eliminate heroin detoxification as a covered benefit under the Medi-Cal Program. I hope you will join us in our opposition to any amendments to the 1990-91 State Budget Act that would remove heroin detoxification services as a Medi-Cal benefit.

California methadone clinics provide daily acute care services to more than 18,000 narcotic dependent patients -- most of whom are low-income and Medi-Cal eligible.

Methadone providers are very concerned about the Governor's proposal to eliminate six benefit categories from Medi-Cal, including heroin detoxification. We understand the reason for the proposed cuts is to reduce Medi-Cal costs, not because the Governor believes the services are unnecessary. However, we are obliged to point out that the money saved by eliminating heroin detoxification programs is relatively small -- only $1.8 million annually -- of which half is reimbursed in federal dollars. Moreover, we believe the proposed cuts would actually cost the state substantially more money in the long run because acutely ill heroin users will simply turn to more expensive county emergency rooms or mental health programs for treatment.

Furthermore, while intravenous heroin users are on the street without care, they are much more likely to participate in criminal activities or come into contact with life threatening communicable diseases such as tuberculosis, hepatitis B, and AIDS.

Methadone clinics are also the only entry point for many low income narcotic abusers into the health care system. Clinics are often able to identify serious diseases at an early stage, thereby reducing the overall cost of individual treatment and preventing the spread of highly contagious diseases to the general population.

The Medi-Cal subsidy is often the primary reason that many eligible narcotic dependent persons first enter methadone treatment. If they would have to pay for the treatment, they would elect to spend their money on illicit substances. The reality of the situation is that if these individuals are not provided some level of inducement, they may never elect to be treated.

Additionally, many of these individuals have subordinated their health care to drug abuse. When entering treatment, we provide urinalysis, blood testing, and a medical evaluation. We often discover communicable and unattended disease such as hepatitis and tuberculosis.

Many narcotic dependent persons first entering treatment come through the outpatient heroin detoxification treatment modality.

Many program participants have not attended to their medical needs for protracted periods of time. Additionally, these individuals are often unwelcome at established medical facilities, because of their drug abuse. The primary patient often has family members, including children, who eventually enter our medical and clinical programs, finally receiving long overdue care.

In short, I believe the Governor's proposal to remove heroin detoxification programs as a Medi-Cal benefit is shortsighted and, in the long run, will be far more expensive to the taxpayers than continuing eligibility under the current program.

I believe that any attention you or your Committee can focus on this issue will be of benefit to the addicted women of California and their families. I thank you again for your interest in this issue.

Sincerely,

Alan Trachtenberg, M.D., M.P.H.
Medical Director

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
WASHINGTON, DC 20515

May 7, 1990

Ms. Kathleen E

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Beyond the Stereotypes: Women, Addiction and Perinatal Substance Abuse," held here in Washington, April 19. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by May 18 with any necessary corrections.

In addition, I am requesting that you respond in writing to the following questions to that they may be included in the hearing record:

1. You said that the punitive treatment model used in the long-term program you completed was not helpful. Based on what your needs were, could you describe what would be helpful for women?

2. What were some of the main obstacles -- physical, emotional or structural -- to seeking and obtaining treatment? Was there support from within your family to seek treatment?

Let me again express my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families
Enclosure

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

MTC Inc.

SOCIAL MODEL DETOX, 14800 SHADY GROVE ROAD, ROCKVILLE, MD 20850
P.O. BOX E, EMMITSBURG, MD 21727

May 15, 1990

Kathleen E

George Miller, Chairman
Select Committee on Children, Youth,
& Families

Dear Mr. Miller:

Thank you for your recent letter, but please know that it was my sincere pleasure, and privilege to have testified before your committee. If I can be of any value in your struggle to help addicted women, please don't hesitate to contact me. Also, thank you for giving my daughter, Erin, so much extra attention. You made her day, one that she will always remember, thank you!

In response to question:

1. Please look over brochure of Mt. Manor's program for women, as I did play a role in designing that program.
   To expand personally, women need longer term options available, like half-way houses where they can live with their children.

2. Included in services should be:

   a. parenting skills
   b. family therapy
   c. social skills (schooling, job interviews, community networking, vocational rehab/training
   d. day care
   e. as 95% of our women have been victims of rape, or abuse they need specialized therapy to include:
      incest, rape, abusive relationships, etc.
   f. motivation to help them off welfare
   g. women need positive peer role models
   h. women who are addicted have double stigmas attached, they need therapy to work through guilt, shame including re-education toward nurturing and love

3. My main obstacle to treatment was the enabling that went on around me. In over seventeen years to think that I was a client of Social Services and I was receiving Federal money, and had five children, had seen countless doctors, and no one even tried to intervene is unbelievable! There is something wrong with our system, called ignorance, Social enabling.

Yes, there was support from my family, after my Dad received treatment, and the family was educated on the disease, they began to do the appropriate things to help, not hinder.

Once again, the culprit is ignorance, alot of misinformed individuals.

Again sir, Thankyou, and God Bless You.

Sincerely,

Kathleen

Kathleen

CCBC

MOUNTAIN MANOR - THE LIBERTY PROGRAM

JUST FOR WOMEN

You have just entered treatment - We know you may be feeling confused, lonely, angry, hurt, guilty, shameful and maybe you don't even know how you feel at all. Many of us have felt like your feeling right now. We have been there. You may also feel no one understands. How could they possibly know how I feel, no one has ever experienced what I have. How could anyone help me.

You probably have some deep secrets you have never allowed yourself to tell anyone. Ask yourself these questions.

1) Do I think about my secrets?

2) What happens to me inside when I think about them?

3) Am I ashamed to tell anyone my secrets?

4) How do I feel with my secrets?

5) What would others think of me?

Our goal is to increase the chances of a full recovery. We feel women who come into treatment carry secrets inside them that are never shared. We are offering special womens groups where she will be encouraged to let go of her secrets.

SECRETS ARE GREAT EQUALIZERS WHEN SHARED.

When we tell others who we really are they are able to share in return. Their sharing of experiences relieves the shame and invites forgiveness of self and others. Such self revelation frees the woman from the power her secrets hold. In womens group she learns that what she thought were shameful acts were not unusual or unique.

DISCOVERY IS THE GIFT TO SHARING.

Sharing our fears, our hopes and our anger makes us more accepting of ourselves and therefore we have less need to cover up. We recognize and celebrate our "sameness" and the freedom that this brings. Sharing ourselves bonds us together thus combining our strength.

Every woman who comes to Mountain Manor is assigned a female primary counselor who directs all aspects of her treatment program. She will participate in daily groups encouraging her to feel safe and develop trust in herself and her peers. She will be encouraged to use the support of her community, groups and staff.

Liberty means freedom from addiction. The success of the liberty program rests in its ability to help each woman develop a positive lifestyle by fostering understanding and acceptance of her disease of alcoholism and drug addiction. The objectives are to halt the tragic progression of the disease by helping her to acknowledge it and by giving her the practical tools to build a successful recovery that leads to productive living.

THE WOMAN'S PROGRAM AT MOUNTAIN MANOR

LIBERTY

A UNIQUE TREATMENT PROGRAM FOR CHEMICALLY DEPENDENT WOMEN

The Liberty Program at Mountain Manor has been in operation since 1983 in response to our realization that women suffering from the diseases of alcoholism and chemical dependency have special needs that are best addressed in a therapeutic program designed specifically for women. The Liberty Program incorporates the principles and philosophy of Alcoholics and Narcotics Anonymous into all aspects of therapy.

Since its creation, the Liberty Program has provided many women with freedom from addiction to alcohol, cocaine, narcotics, prescription medications and other drugs so that they, their families and friends may live healthy, productive, rewarding lives.

It is the goal of the Liberty Program at Mountain Manor to provide each woman the means of achieving a lifestyle totally free from alcohol and drugs. We foster in each woman the development of positive self esteem and healthy socialization skills which serve as an acceptable alternative to her previously destructive coping techniques.

WHAT MAKES OUR PROGRAM UNIQUE

The Liberty Program at Mountain Manor is unique. We allow a woman to bring her minor children with her into treatment. We have found all too often that women will use the burden of their parental responsibilities as a justification for avoiding inpatient treatment. We eliminate this barrier to recovery by allowing the children to come to Mountain Manor and live in the same room with their mother. We have developed extensive ties with the Emmitsburg, Maryland kindergarten and elementary school systems, which coordinate with the child's home school system to develop an educational plan tailored to the child's educational needs while the mother is in treatment. Daycare services are provided at the Mother Seton Daycare Center.

We have discovered when a mother is accompanied by her children at Mountain Manor, not only does the specific parent child relationship strengthen and improve through the course of the recovery process, but the entire therapeutic community benefits from the children's presence with increased awareness and sensitivity to those around them.

An extensive series of lectures has been created addressing each topic as sexuality, parenting skills, job skills and interviewing techniques, educational needs assessment, financial management, personal grooming, relationships and self-image.

RECOVERY BEGINS WITH LOVE AND UNDERSTANDING.

Mountain Manor provides a quality environment of healthcare and recovery which has been its tradition for over fourteen years. Our loving and nurturing staff provides a therapeutic environment which encourages positive change and positive self-image. We recognize each woman as a person of dignity and worth whom we accept in a genuine spirit of respect and high regard.

THROUGH THE RECOVERY PROCESS, NEW HORIZONS OF SELF-DISCOVERY ARE OPENED.

Every woman who comes to Mountain Manor is assigned a primary counselor who coordinates all aspects of her treatment program. She participates in daily women's group sessions which address issues of specific concern to women. In this setting, women can feel safe with dealing with women's issues and secure in developing their commitment to long term recovery.

BUILDING A NEW SELF-IMAGE.

The Liberty Program affords each woman the opportunity to look deeply within herself to discover her own self worth and to begin to love herself. We encourage each woman to share with others in her women's group those feelings and circumstances which she feels have isolated her. It is said that secrets are great equalizers when shared. The sharing experience releases the feelings of guilt, shame and helplessness and invites forgiveness of self and others. This discovery of self worth is the gift of sharing.

LIBERTY MEANS FREEDOM FROM ADDICTION.

The success of the Liberty Program rests in its ability to help each woman develop a positive lifestyle by fostering understanding and acceptance of the diseases of alcoholism and drug addiction. The objectives are to halt the tragic progression of the disease by helping the individual acknowledge it and giving her the practical tools to build a successful recovery that leads to productive living.

THE RECOVERY PROCESS:

The Liberty Program embodies an approach to treatment that is both holistic and multidisciplinary, incorporating medical, counseling, restorative and social skills. The program is comprehensive and multifaceted.

The treatment professionals, composed of certified addiction counselors, doctors and nurses, recreational and vocational therapists, provide a highly structured program of therapy and education to help women confront their illness effectively and to identify a realistic path to recovery.

Individual Counseling - The individual counselor works closely with the female patient to prepare and implement individualized treatment plans. The counselor assists the patient in identifying problems and providing direction to formulate a plan for growth and continued sobriety.

Group Counseling - Through peer identification, patients share the disease of chemical dependency and the accompanying progressive problems and frustrations. Daily group therapy increases understanding of the illness and builds self-acceptance.

Medical Supervision - Our Medical Director and nursing staff provide comprehensive, ongoing medical supervision. They have specialized expertise in dealing with health problems stemming from chemical dependency.

Family Counseling - Family involvement is an integral part of the treatment and recovery process. Identifying family roles and reestablishing communication among all members is the key to recovery. We strongly urge family members to participate in various counseling activities.

Vocational Counseling - During the treatment, each woman's vocational needs and objectives are assessed. When appropriate, job skills enhancement and training are made available.

Recreational Therapy - As part of our treatment program, patients are encouraged to pursue interests, hobbies and skills, to renew their interests in sports activities and exercise.

Nutrition - Chemical dependency often causes nutritional deprivation. Our trained staff, with the aid of a registered dietician, create appetizing meals suited to each patient's nutritional needs.

Discharge Planning - As the patient nears completion of the program, discharge planning helps provide for an effective transition by insuring support for the recovery process.

Continuing Care - A comprehensive aftercare program is a vital element in the patient's recovery process. Aftercare is individually devised to include an assessment of patient goals, post-treatment therapy, support groups and commitment to Alcoholics or Narcotics Anonymous attendance.

U.S. House of Representatives
SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES

May 7, 1990

Reed V. Tuckson, M.D.
March of Dimes Birth Defects Foundation
Public Affairs Office
1725 K Street, N.W., Suite 814
Washington, DC 20006

Dr. Tuckson:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Beyond the Stereotypes: Women, Addiction and Perinatal Substance Abuse," held here in Washington, April 19. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by May 18 with any necessary corrections.

In addition, I am requesting that you respond in writing to the following questions so that they may be included in the hearing record:

1. Mr. Bosharov said that, for the crack problem, he didn't feel that lack of insurance and inadequacy of insurance was a major problem, because most crack users were Medicaid eligible. In your experience in the District of Columbia, did you find that Medicaid coverage was adequate to cover treatment needs of pregnant addicts?

2. Last October, Jennifer Howse, President of the March of Dimes Birth Defects Foundation, testified before the Select Committee about the "organizational barriers" to prenatal care and the March of Dimes Campaign for Healthier Babies. What is the status of the campaign? Has it succeeded in identifying model programs where institutional changes have improved participation in prenatal care? Could you identify some of these models? Do they facilitate access for addicted pregnant women as well?

3. In your testimony you mentioned that the spread of crack-cocaine wiped out the progress made by initiatives in the District to improve access to prenatal care. What were some of those initiatives? Where did pregnant substance abusers wind up for treatment? What were specific problems stemming from crack use and were any programs developed which addressed these problems?

4. Recently, Secretary Bennett insisted that the War on Drug Abuse in the Capitol was not a failure, although the results were admittedly mixed or unmeasurable. How would you rate the success of the federal effort to check drug use in the District of Columbia? Based on your experience in the District, how might you construct a plan of attack against the city's drug problem?

Let me again express my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

QUESTION #1

The District provides a very generous Medicaid program compared to the nation as a whole and was among the first states to cover pregnant women up to 185% of the federal poverty guidelines. Unfortunately, despite this coverage, it was our experience that a tragically large number of persons still fall through the cracks in the health insurance net. The District of Columbia, a city of approximately 620,000 people, currently has 114,000 citizens who are without any health insurance, public or private. A significant number of these are women of childbearing age. This is not inconsistent with the national profile. Our information is that 9 million American women of childbearing age are without insurance and another 5 million who are insured are without maternity coverage.

Our experience vividly teaches that, because substance abuse knows no economic or class boundaries, there are many women who need care but who can't afford private insurance and/or don't qualify for Medicaid, even at the 185% of poverty guideline. In addition, the barriers to accessing the Medicaid system for those who are eligible can be formidable. Staff shortages that are endemic to the social service system make eligibility determination cumbersome and the dream of a decentralized, clinic-based system is currently unattainable. In addition, the computer system needed for implementation of presumptive eligibility determination, in light of the fiscal constraints of the city, is equally unattainable at

this time. For the growing number of Latino newcomers, the linguistic and cultural barriers to accessing the Medicaid program are equally significant.

We must also remember that relatively few health professionals are willing to accept the small sums that Medicaid pays for the care of these complex patients. The public care system is already inadequate to meet the growing demand. The combination of all of these factors argues against any simplistic assumption that Medicaid financing is adequate to manage a problem of this magnitude.

QUESTION #2

The Institute of Medicine suggested that there are financial and non-financial barriers to access to prenatal care. In an attempt to address these issues, the Greater New York Chapter introduced the Hospital Project as part of the Campaign for Healthier Babies. Forty-four hospitals were surveyed and assessed for innovative solutions to increasing access to prenatal care. Several institutions were identified as being successful in addressing this problem. Two institutions, St. Mary's of Brooklyn and St. Vincent's Medical Center of Richmond, Staten Island, were targeted for more intensive study.

Initital conferences to acquaint administrators and clinicians with the innovations were held, then a series of conferences spotlighting specific innovations were given. The first series addressed a time appointment system. Topics discussed at other mini-conferences included: models of continuity of care, problem-oriented perinatal risk assessment, and programs for substance-abusing women. A manual from each conference was developed to facilitate replication in the participant's institution. The Individual conferences offered have been evaluated positively by attendees. In addition, a program to assist hospitals in reimbursement was undertaken and the total impact of these programs is presently being evaluated.

QUESTION #2

Presently, the possibility of implementation of the program in other sites across the country is being investigated. Three cities have demonstrated interest: Detroit, San Francisco and Gainsville. Preliminary discussions are taking place.

QUESTION #3:

At the beginning of my tenure as the District's Commissioner of Public Health in 1986, we initiated a series of interventions designed to educate pregnant women about the importance of early and continuous prenatal care, to motivate them to use the available services and to facilitate their access to care by eliminating the multiple barriers that often impeded access. As such we made care free to any person earning less than $20,000/year; provided transportation and outreach services through the development of a Maternity Outreach Mobile (MOM Van); extended clinic hours into the evenings in the poorest sections of the city; eliminated block appointment scheduling and guaranteed appointments within two weeks of the initial call; provided on site child care services; and made extensive use of the media and innovations such as redeemable coupons for compliance with clinic appointments as educational and motivational tools. We observed a 22% increase in clinic visits for prenatal care and a decrease of 6% in our subsequent years' infant mortality statistics. Unfortunately, the crack cocaine epidemic among women of childbearing age destroyed this modest success.

The District's drug treatment system, like all other major American cities, was simply unable to meet the extraordinary rise in demand in general and for pregnant women in particular. As such, we made a decision to treat the pregnant substance abuser as a priority and, regardless of any other considerations, to treat the pregnant woman on demand. The Alcohol and Drug Abuse Services Administration was reorganized to eliminate the bureaucratic barriers to accesss and

QUESTION #3

the service capacity for pregnant women was augmented by shifting resources away from other areas. In addition, a second "MOM" Van was created to specifically reach out to the immediately post partum substance abuser, while she was still hospitalized, to capture her into the treatment system and follow her and the baby at home in an attempt to prevent future problems and to track the development of the infant through at least the first year of life.

It was our observation that there needs to be an enhanced linkage between the providers of the prenatal care and the substance abuse treatment system and more attention given to the development of a case management system that addressed the multiplicity of defects that plague the substance abusing pregnant woman. We also came to appreciate the need for much more research into the clinical management of these patients. We really do not have a very sophisticated treatment regimen available for the crack addicted pregnant woman in particular, or for the other drugs of abuse in general. We are pleased that the Office of Substance Abuse Prevention and the Office of Treatment Improvement in HHS are now addressing these issues, but they need a much more significant investment of resources if they are to be successful.

QUESTION #4

The "war" on drugs in the District remains a protracted struggle that, despite the good efforts of many committed persons and organizations, cannot by any criteria be considered a success. Mr. Bennett's concentration did not address what, in my opinion, are the major determinants for success. If we really believe that prevention is the key, then our efforts will need to be more focused and committed on addressing the root etiological causes of substance abuse that are found at the heart of the community infrastructure of the city. We need to work on creating the concept of the possibility of a meaningful future for our youth and young adults, if we will have a chance of convincing them not to use drugs and alcohol. Unless this soil is developed and tilled, then the education and treatment seeds that we plant will not bear fruit.

This suggests that two related efforts must occcur simultaneously. First, real attention needs to be given to community economic development that creates jobs for which skills need to be and can be acquired to fullfill. Secondly, the leadership of the community, in all of its manifestations - from media to minister - needs to work on the value system that defines "meaningful". The real effort here is to rebuild the community infrastructure based upon a principled and ethical dedication to improving the quality of life for all. What these two strategies are <u>not</u> about is a preoccupation

QUESTION #4

with criminal justice solutions to the problem. If the district teaches any lesson, it's that above all we've learned that you can lock up thousands of people and not make any dent into the problem.

Let me hasten to mention that prior to, and outside of, the political posturing that occurred between Mr. Bennett's office and the D.C. Government, a great deal of substantive work was begun between the Commission of Public Health and the Department of Health and Human Services under the leadership of Dr. Louis Sullivan. A four component effort was agreed upon and is well along the way to implementation that included: 1) the development of a comprehensive prevention plan with each ward's leadership that involved and facilitated neighborhood leadership in addressing the problems with health professionals; 2) the expansion of the outpatient drug treatment capacity by 300 slots and the use of these new slots to evaluate the developing state of the art drug treatment therapies; 3) the development of a model diagnostic unit at the central intake facility to enable a better individual treatment assessment and to facilitate outcome evaluations; and 4) the assistance of the resources of the Public Health Service in having all levels of the District's alcohol and drug treatment staff to better meet the challenges of increasingly more complex patients. This work was conducted in good faith and with commitment by both

QUESTION #4

parties, but did not receive the publicity that other efforts seemed to attract.

I would hope that the Secretaries of Education, Commerce, Housing and Urban Development, and Health could be convened by the President for a real "war" on drugs.

[illegible]

U.S. House of Representatives

SELECT COMMITTEE ON
CHILDREN, YOUTH, AND FAMILIES
[illegible]
WASHINGTON, DC 20515

[illegible]

May 7, 1990

Ms. Iris Smith, M.P.H.
Georgia Addiction, Pregnancy and
Parenting Program
Room 324 W, GMHI
1256 Briarcliff Road
Atlanta, GA 30306

Ms. Smith:

I want to express my personal appreciation to you for appearing before the Select Committee on Children, Youth, and Families at our hearing, "Beyond the Stereotypes: Women, Addiction and Perinatal Substance Abuse," held here in Washington, April 19. Your testimony was, indeed, important to our work.

The Committee is now in the process of preparing the transcript for printing. It would be helpful if you would go over the enclosed copy of your remarks to assure that they are accurate, and return the transcript to us by May 18 with any necessary corrections.

In addition, I am requesting that you respond in writing to the following questions so that they may be included in the hearing record:

1. You mentioned that one of the primary objectives of your program is to identify factors motivating women to seek treatment. Have you any ideas about what some of those factors might be?

2. We often assume that self-help, mutual support organizations like AA and NA are there to see people through their post-treatment struggle to stay drug-free. It is very disturbing to hear that, in Atlanta at least, most of these "12 step" type groups are inaccessible to women whose need may be the greatest -- those that live in black, low-income communities. Why are the groups so rare in the inner city? What could public or private agencies do to encourage their accessibility?

3. You say there should be multiple measures of program success, because short relapses and failure are not the same thing.

Other than those you mentioned in your testimony, are there any other indicators of program success you find meaningful and useful? Are there any questionnaires or instruments that could help standardize some of this information so that we could make comparisons across different types of programs?

Let me again express my thanks, and that of the other members of the Committee, for your participation.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

Enclosure

RESPONSE TO QUESTIONS POSED BY CHAIRMAN GEORGE MILLER

The Georgia Addiction, Pregnancy and Parenting Project

Georgia Mental Health Institute + 1256 Briarcliff Road, N.E.
Atlanta, Georgia 30306
Telephone (404) 894-8288

May 31, 1990

George Miller
Chairman
Select Committee on Children, Youth and Families
U.S. House of Representatives
385 House Office Building Annex 2
Washington, D.C. 20515

Dear Representative Miller:

As you requested, I have edited the transcript of the April 19th hearing, "Beyond the Stereotypes: Women, Addiction and Perinatal Substance Abuse". Thank you for giving me the opportunity to address the committee. Substance abuse, particularly among pregnant women, is a pervasive and extremely complex social problem for which there are no readily available solutions. It is important that we begin to clarify some of the issues involved, in order to formulate realistic and meaningful goals in our efforts to intervene with both the addicted mothers and their children.

I would like to respond to the questions you raised regarding my testimony.

1. In 1985, we conducted a comparison study of women who were entering drug treatment programs in the metro Atlanta area and pregnant and post partum addicts who were being referred to our intervention program. The results of our study indicated that women who were entering treatment programs were significantly more impaired psychologically and socially. As a group, the pregnant and post partum addicts tended to report fewer social and family problems, less anxiety and psychological distress and in general were more satisfied with their lives. They were younger than the women who were seeking treatment and were more likely to have dependent children in the home. These findings tend to support the belief that individuals who seek treatment are generally those who have "hit bottom", i.e. individuals who have experienced severe social, psychological and/or medical problems as a result of their addiction. The pregnant and post-partum addicts had been less adversely affected by their addiction and thus were more likely to deny that drug use was a problem.

These findings have several implications for prevention and intervention with pregnant and post partum addicts. First, time is of critical importance when intervening with pregnant women. Obviously, we cannot afford to wait until the mother "hits bottom" and decides to enter treatment. Active casefinding and agressive outreach are essential in working with this population. While it is important to be sensitive to the multiple problems and and social barriers these women face, it is equally important to be willing to use confrontation techniques when necessary to help break through denial and help the client face her addiction. GAPP outreach workers work intensively with clients in their homes, using a combination of supportive,

confrontational and educational strategies to break through the denial and motivate women to seek help. In working with our clients, we have found that there is a critical "window" during the immediate post partum period (the first 30 days following delivery) when there is the greatest risk for relapse. Psychosocial support during this period is very important. Prevention of relapse in the new mother is extremely important, since many of these women will have subsequent pregnancies.

Another useful strategy is to utilize existing family supports. Involving the family in the treatment planning and the aftercare program is also important.

As noted above, our study also indicated that women who did enter treatment programs were less likely to have dependent children in the home. Our program does provide 24 hours childcare placements for women with children. The children are placed with licensed childcare providers who meet with the mothers prior to placement. This is a relatively new component of our program, but we have found that this option tends to improve compliance and retention in treatment.

As you know, one of the greatest barriers to treatment has been the limited number of treatment beds available. Our experience over the last 3 1/2 years has indicated that there are significantly more women who are motivated to seek treatment than there are spaces available.

2. Self-Help Groups. The limited accessibility of 12 step groups in the inner city communities is difficult to explain. In part, it is due to the fact that there are few "safe" meeting places available in some communities. Another factor may be that such groups often fail to consider the culture-specific concerns of the minority communities and their "mainstream" approach may be less effective with these populations. Young mothers, in particular, often have difficulties with transportation and childcare which are usually not addressed by 12 step groups. Community based aftercare support is essential for the recovering addict. Community education may be helpful in sensitizing communities to this aspect of the problem. Often community empowerment begins with education. In Atlanta, we have been working with several churches who are interested in developing community based programs. What we have found is that often there are individuals willing to help who simply do not know what they can do.

3. Program Success. The ultimate goal of any prevention/intervention program for pregnant addicts is a drug free pregnancy. Intervention during a pregnancy may prevent a drug use in a future pregnancy. Addiction is seldom an "all or nothing" phenomena. Most addicts will relapse. During the later phases of recovery, these relapses should occur less frequently and be of shorter duration. There are a number of instruments which can be used to measure progress. For example, the Addiction Severity Index (ASI) (McClleland, 1983) has been used by substance abuse programs as an evaluation instrument. It measures seven domains of functioning: psychiatric status; medical status; employment status;drug and alcohol use; legal problems; family and social relationships. Positive changes in any of these areas indicates a measure of "success".

Please let me know if I can provide you with any additional information. As we proceed with the analysis of data from our program, I will be happy to share information from our evaluation study as it becomes available.

Sincerely yours,

Iris E. Smith

Iris E. Smith, M.P.H.
Director
Prevention & Applied
Research

31-228 (204)

END

U.S. Dept. of Education

Office of Education
Research and
Improvement (OERI)

ERIC

Date Filmed

March 21,1991